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Kaiser Permanente Medical Care Program Oral History Project

Harry Shragg, M.D.

HISTORY OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

An Interview Conducted By
Ora Huth
in 1986

It is recommended that this oral history be cited as follows:

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HARRY SHRAGG, M.D.

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PREFACE

Background of the Oral History Project

The Kaiser Permanente Medical Care Program recently observed its fortieth anniversary. Today, it is the largest, one of the oldest, and certainly the most influential group practice prepayment health plan in the nation. But in 1938, when Henry J. and Edgar F. Kaiser first collaborated with Dr. Sidney Garfield to provide medical care for the construction workers on the Grand Coulee Dam project in eastern Washington, they could scarcely have envisioned that it would attain the size and have the impact on medical care in the United States that it has today.

In an effort to document and preserve the story of Kaiser Permanente's evolution through the recollections of some of its surviving pioneers, men and women who remember vividly the plan's origins and formative years, the Board of Directors of Kaiser Foundation Hospitals sponsored this oral history project.

In combination with already available records, the interviews serve to enrich Kaiser Permanente's history for its physicians, employees, and members, and to offer a major resource for research into the history of health care financing and delivery, and some of the forces behind the rapid and sweeping changes now underway in the health care field.

A Synopsis of Kaiser Permanente History

There have been several milestones in the history of Kaiser Permanente. One could begin in 1933, when young Dr. Sidney Garfield entered fee-for-service practice in the southern California desert and prepared to care for workers building the Metropolitan Water District aqueduct from the Colorado River to Los Angeles. Circumstances soon caused him to develop a prepaid approach to providing quality care in a small, well-designed hospital near the construction site.

The Kaisers learned of Dr. Garfield's experience in health care financing and delivery through A. B. Ordway, Henry Kaiser's first employee. When they undertook the Grand Coulee project, the Kaisers persuaded Dr. Garfield to come in 1938 to eastern Washington State, where they were managing a consortium constructing the Grand Coulee Dam. Dr. Garfield and a handful of young doctors, whom he persuaded to join him, established a prepaid health plan at the damsite, one which later included the wives and children of workers as well as the workers themselves.

During World War II, Dr. Garfield and his associates--some of whom had followed him from the Coulee Dam project--continued the health plan, again

at the request of the Kaisers, who were now building Liberty Ships in Richmond, California, and on an island in the Columbia River between Vancouver, Washington and Portland, Oregon. The Kaisers would also produce steel in Fontana, California. Eventually, in hospitals and field stations in the Richmond/Oakland communities, in the Portland, Oregon/Vancouver, Washington areas, and in Fontana, the prepaid health care program served some 200,000 shipyard and steel plant employees and their dependents.

By the time the shipyards shut down in 1945, the medical program had enough successful experience behind it to motivate Dr. Garfield, the Kaisers, and a small group of physicians to carry the health plan beyond the employees of the Kaiser companies and offer it to the community as a whole. The doctors had concluded that this form of prepaid, integrated health care was the ideal way to practice medicine. Experience had already proven in the organization's own medical offices and hospitals the health plan's value in offering quality health care at a reasonable cost. Many former shipyard employees and their families also wanted to continue receiving the same type of health care they had known during the war.

Also important were the zeal and commitment of Henry J. Kaiser and his industry associates who agreed with the doctors about the program's values and, despite the antagonism of fee-for-service medicine, were eager for the success of the venture. Indeed, they hoped it might ultimately be expanded thoughout the nation. In September, 1945, the Henry J. Kaiser Company established the Permanente Health Plan, a nonprofit trust, and the medical care program was on its way.

Between 1945 and the mid-1950s, even as membership expanded in California, Oregon, and Washington, serious tensions developed between the doctors and the Kaiser-industry dominated management of the hospitals and health plan. These tensions threatened to tear the Program apart. Reduced to the simplest form, the basic question was, who would control the health plan--management or the doctors? Each had a crucial role in the organization. The symbiotic relationship had to be understood and mutually accepted.

From roughly 1955 to 1958, a small group of men representing management and the doctors, after many committee meetings and much heated debate, agreed upon a medical program reorganization, including a management-medical group contract, probably then unique in the history of medicine. Accord was reached because the participants, despite strong disagreements, were dedicated to the concept of prepaid group medical practice on a self-sustained, nonprofit basis.

After several more years of testing on both sides, a strong partnership emerged among the health plan, hospitals, and physician organizations. Resting on mutual trust and a sound fiscal formula, the Program has attained a strong national identity.

The Oral History Project

In August 1983, the office of Donald Duffy, Vice President, Public and Community Relations for Kaiser Foundation Health Plan and Hospitals, contacted Willa Baum, director of the Regional Oral History Office, about a possible oral history project with twenty to twenty-four pioneers of the Program. A year later the project was underway, funded by Kaiser Foundation Hospitals' Board of Directors.

A project advisory committee, comprised of seven persons with an interest in and knowledge of the organization's history, selected the interviewees and assisted the oral history project as needed. Donald Duffy assumed overall direction and Darlene Basmajian, his assistant, served as liaison with the Regional Oral History Office. Committee members are John Capener, Dr. Cecil Cutting, Donald Duffy, Robert J. Erickson, Scott Fleming, Dr. Paul Lairson, and Walter Palmer.

By year's end, ten pioneers had been selected and had agreed to participate in the project. They are Drs. Cecil Cutting, Sidney Garfield, Raymond Kay, Clifford Keene, Ernest Saward, and John Smillie, and Messrs. Frank Jones, George Link, Eugene Trefethen, Jr., and Avram Yedidia.

By mid-1985 an additional ten had agreed to participate. They are: Drs. Morris Collen, Wallace Cook, Alice Friedman, Benjamin Lewis, Sam Packer, Bill Reimers, Harry Shragg, and David Adelson, Lambreth (Handy) Hancock, and Berniece Oswald.

Plans to interview Dr. Garfield and Dr. Wallace Neighbor, who had been at Grand Coulee with Dr. Garfield, were sadly disrupted by their deaths a week apart in late 1984. Fortunately, both men had been previously interviewed. Their tapes and transcripts are on file in the Central Office of the medical care program. Similarly the project lost Karl Steil due to his lengthy illness and death in 1986.

The advisory committee suggested 1970 as the approximate cutoff date for research and documentation, since by that time the pioneering aspects of the organization had been completed. The Program was then expanding into other regions, and was encountering a new set of challenges such as Medicare and competition from other health maintenance organizations.

Research

Kaiser Permanente staff and the interviewees themselves provided excellent biographical sources on each interviewee as well as published and unpublished material on the history of the Program. The collected papers of Henry J. Kaiser on deposit in The Bancroft Library were also consulted. The oral history project staff collected other Kaiser Permanente publications, and started a file of newspaper articles on current health care topics. Most of this material will be deposited in The Bancroft Library with the oral history volumes. A bibliography is located at the end of the volume.

To gain additional background material for the interviews, the staff talked to five Kaiser Permanente physicians in northern California, two of whom had left the program years ago: Drs. Martin Abel, Richard Geist*, Ephraim Kahn*, James Smith*, and William Bleiberg*. James De Long* in Portland, and William Green*, William Allen*, and Dr. Toby Cole* in Denver talked about the history of their regions. In addition, Peter Morstadt*, formerly executive director of the Denver Medical Society discussed the attitude of the Medical Society toward Kaiser Permanente's years in Denver.

The staff also sought advice from the academic community. James Leiby, a professor in the Department of Social Welfare at UC Berkeley and an advocate of the oral history process, suggested lines of questioning related to his special interest in the administration of and relationships within public and private social agencies. Dr. Philip R. Lee, professor of social medicine and director of the Institute for Health Policy Studies at the University of California Medical School, proposed questions concerning the impact of health maintenance organizations on medical practice in the United States.

Organization of the Project

The Kaiser Permanente Oral History Project staff, comprised of Malca Chall, Sally Hughes, and Ora Huth, met frequently throughout 1985 to assign the interviews, plan the procedures and the time frame for research, interviewing, and editing, and to set up a master index. Interviews with the first nine pioneers took place between February and June, 1985, and with the second group between February and December, 1986. The transcripts of the tapes were edited, reviewed by the interviewees, typed, proofread, indexed, copied, and bound. The entire series will be completed during 1987.

Summary

This oral history project traces, from various individual perspectives, the evolution of the Kaiser Permanente Medical Care Program from 1938 to 1970. Each interview begins with a discussion of the individual's family background and education--those tangible and intangible forces that shaped his or her life. The conversation then shifts to the interviewee's participation in and observation of significant events in the development of the health plan. Thus, the reader is treated not only to facts on the history of the Program, but to opinions about the personal qualities of the men and women--doctors, other health care professionals, lawyers, accountants, and

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*Tapes of these interviews have been deposited in the Microforms Division of The Bancroft Library.

businessmen--who, often against great odds, dedicated themselves to the development of a health care system which, without their commitment and skills, might not have resulted in the individual and organizational achievements that the Kaiser Permanente Medical Care Program represents today.

The Regional Oral History Office was established to tape record autobiographical interviews with persons who have contributed significantly to the development of the West. The office is headed by Willa K. Baum and is under the administrative supervision of James D. Hart, the director of The Bancroft Library.

Malca Chall, Director
Kaiser Permanente Medical Care Program
Oral History Project

23 January 1987
Regional Oral History Office
Berkeley, California

INTERVIEW HISTORY

Dr. Harry Shragg has had a distinguished career as a surgeon and administrator for the Southern California Kaiser Permanente Medical Care Program. During three decades with Kaiser Permanente he has served in a number of capacities throughout the region: in Harbor City as surgeon, chief of the Department of Surgery, administrator of a community health care program for indigents, as well as medical director; in the West Los Angeles Area as medical facilities planner, and as medical director, a post he has held since 1971. He continues today with oversight responsibility for structures, equipment, and patient care at three clinic-hospitals, two in West Los Angeles, and one in Inglewood.

Dr. Shragg was born in Minneapolis, Minnesota, on August 19, 1924, in Hennepin County General Hospital where he later interned and where the first of his two children were born. Minneapolis, with its progressive labor movements and proximity to group medical practice models (for example, the Duluth and Mayo Clinics), was the setting for his social, spiritual, and scholastic enlightenment through high school graduation in 1943 to 1947, and internship at the county hospital in 1947-1948. General practice for three years in Blue Earth, Minnesota, and for two years as Army Air Force reservist during the Korean War in Great Falls, Montana, culminated in specialization and residency in surgery at Minneapolis Veterans Hospital from 1953 to 1957. A visit to California prompted a desire to locate in or near Los Angeles. Subsequently, he was offered and accepted a surgical post with the Southern California Permanente Medical Group (SCPMG) in Harbor City--leading to what he describes as a "high quality professional relationship" and superlative "quality of life."

In his memoir, Dr. Shragg notes that in Minneapolis he was surrounded by peers who made medicine their lifework, that two of his brothers became physicians, that the third brother studied medicine for one year, and that his son, Bruce, a radiologist, had his residency with the SCPMG. He names some ten relatives and friends from his two-to-three-block neighborhood who joined SCPMG, some of whom are leaders in the group.

Dr. Shragg describes his surgical practice with SCPMG as "like being a super medical resident," but he points to problems accommodating medical staff egos and personalities when, as chief of surgery, he tried "to get people to work together." He is magnanimous in describing special physician copartners as "giants in their fields--kind, nice people--excellent, and unique," while adding that "group practice is not for everyone."

The two interviews were recorded in Dr. Shragg's office in the Cadillac Avenue medical center in West Los Angeles. An outline presenting the scope and topics to be covered was sent in advance, and appropriate sections were discussed and adjusted before the interviews. During the preinterview conference before the one and one-half-hour session on April 25, 1986, Dr. Shragg spoke of the attributes of several SCPMG pioneers, hoping they could somehow be included in the oral history project. He wore his white clinician's coat, which he said is his way of reminding associates that he is a physician-administrator, although he no longer is a practicing surgeon. He responded to interview questions with candor and enthusiasm. Lunch hosted by Dr. Shragg in the center's cafeteria provided a pleasant interruption for the intensive seven-hour session on April 29, 1986. He received the lightly edited transcript of the entire nine-hour session and returned it in a timely manner, with revisions providing more accurate information.

Dr. Shragg recounts his aspirations, roles, posts, and pursuits over some sixty years, including his plans for plastic surgery retraining when he retires at age sixty-five. In telling his story he provides the reader with a sense of his integrity, character, and boundless energy, as he worked toward predetermined goals. The concerns of people were always uppermost in his mind. For example, when asked what was important in his career, he said he met "some fabulously wonderful people" in "all these years," and "people are probably the most important thing." However, he added:

> Being involved with planning, developing, architecture, and seeing something grow has been a major plus in my career. And learning through some of my past mistakes and other people's mistakes--how to do things better... it is important to push for something you think is right rather than giving up. Sometimes you have to buck the system.

Speaking of the responsibility as medical director, he said:

> The most important thing is that you are here to take care of the patient. Probably the next most important job is to select quality people, especially the chiefs of service...and to terminate someone in a timely enough manner--who may not be up to the standards. It is essential to have a doctor as medical director because non-physicians never see a patient...never see a bleeder; they never see somebody who's in pain, or somebody in a wheelchair...Our quality of service is very important,

> and that's a product of training, of upbringing, of education. There is a need for developing mutual trust.

As to the need for innovation, he added:

> As we get older and more structured we get to what Dr. Jack Gordon calls "hardening of the categories." It's part of our being big, and we have too many boxes where people isolate themselves in a box...we need more Sidney Garfields, Buck Wallins, and Ray Kays. We have to be more creative and innovative. It's harder to do these days with all the external forces that go along with it.

Ora Huth
Interviewer-Editor

23 October 1987
Regional Oral History Office
486 The Bancroft Library
University of California
Berkeley, California

Regional Oral History Office
Room 486 The Bancroft Library

University of California
Berkeley, California 94720

BIOGRAPHICAL INFORMATION

(Please print or write clearly)

Your full name HARRY SHRAGG

Date of birth Aug 19/1924 Place of birth Minneapolis, Minn

Father's full name MORRIS SHRAGOWITZ

Birthplace KletsK POLAND (maybe Russia).

Occupation TAILOR

Mother's full name EVA ROCHLIN (maiden name) SHRAGOWITZ

Birthplace SLUTSK, POLAND (maybe RUSSIA at the time)

Occupation Housewife

Where did you grow up ? Minneapolis, Minn

Present community Los Angeles

Education Please refer to my C.V.

Occupation(s) VARIOUS JOBS while going to School including Theatre usher, Street car conductor, Newspaper route, PAINTING Stucco houses

Special interests or activities Athletics - Tennis, golf, music, gardening.

I FAMILY BACKGROUND, EDUCATION, EARLY WORK, AND ARMY SERVICE, 1924-1955

[Interview 1: April 25, 1986]##

Early Life, Schooling, and the Minnesota-Kaiser Permanente Connection

Huth: Today we're in Dr. Harry Snragg's office in the Kaiser Permanente Medical Center in West Los Angeles.

Doctor Snragg, let's begin with questions about you and your family. To start with, when and where you were born?

Snragg: I was born on August 19, 1924 in Minneapolis, Minnesota. I am the oldest of four living brothers. Two others are physicians--one is still in Minneapolis, and my youngest brother, Sam, is the chief of radiology with the Southern California Permanente Medical Group at Woodland Hills, and has been with our group, I think, also some twenty years now.

Huth: Did you live all of your early years in Minneapolis?

Shragg: Yes.

Huth: So you went to grammar school there?

Shragg: Grammar school--grad school. North Minneapolis Lincoln Junior High School, North High School, and the University of Minnesota.

Huth: And they're all located in one place?

Snragg: All in Minneapolis.

##This symbol indicates that a tape or a segment of a tape has begun or ended. For a guide to the tapes see page 130.

Huth: Will you please tell me about your high school years--what your interests were at that time, and whether you worked at all while you were in high school? Did you have a job, or particular hobbies?

Shragg: Yes. My mother died when I was fourteen, and I was left with my father, who was a tailor--born in Russia, and who emigrated to the United States in about 1923. I was born at the Minneapolis General Hospital, which is the county hospital. My father's name was Morris Shragowitz. I shortened my last name to Shragg in 1945.

So I started to work when I was fifteen, at night, as an usher in the theatre on the university campus, as my first job while I continued to go to high school. During high school I would say my hobbies and interests outside of school and working towards going to college probably would be athletics, although I did not participate in any official high school athletics except tennis. But tennis, and basketball and so forth. Most of my time was really preoccupied with school, school activities, and then working nights after I was fifteen.

Subsequently, when I started college, I worked as a streetcar conductor. I did odd jobs in the summertime: stuccoing or repainting houses, and all sorts of odd jobs to help. I went to the university literally twelve months a year because, since I was working nights when I completed high school, I had nothing to do in the daytime, so I started my premedical school education. I did this during the summer, and just continued on a twelve-month basis--at least until World War II started. And then I was drafted into the service, and fortunately assigned to return to medical school to complete my medical school education and training.

Huth: That's very unusual, I think, to stay in one place for all that time. Most of the people we're interviewing have moved to various places.

Shragg: Well, we couldn't afford it, and the idea of moving and traveling in high school--unless, I guess, you had some funds or monies--just was foreign to myself and to our family, at least during those years. I can't say the same for my children, who have traveled extensively.

But also, my side interest was music, and although I was not actively involved, I did take violin lessons. But I quit, and I still enjoyed music, but not as an expert in anything.

Huth: Did your brothers also work at the time that you were in high school?

Shragg: Yes, my younger brother, Bob, who's still in Minneapolis, is also a family practitioner in private practice. He essentially did the same thing, although his premedical school education was interrupted by a stint in the navy as an enlisted man. He completed his medical school training in 1953.

My third brother, Esser, is an actuary and he works for the National Cash Register Company in Sacramento. He actually also was in medical school, and after a year, however, was turned off by the medical school training and quit. And there is my youngest brother, Sam, who is a radiologist with Permanente here. They all did odd jobs during the summertime, evenings, that sort of thing.

Huth: That's quite a medical history in your family, as far as interest in medicine. Were there any uncles or aunts, or anyone in your family background that was in medicine? How do you think this came about?

Shragg: No. Well, all of my relatives of that generation, including my father and mother were either shoemakers or tailors in Russia, and all emigrated at about the same time. An older uncle of mine has a son, Bob, who is also a physician, and is the associate medical director at Panorama City.

Huth: He's a cousin?

Shragg: He's a cousin. He actually joined Permanente about three years before I did, and he also went through the same background with hard work and odd jobs to support himself as much as he could. He also attended the University of Minnesota, with all of the same schooling and background that I had. In fact, we lived in the same neighborhood.

An interesting sidelight, I think, is that there were a significant number of physicians from Minneapolis, all of whom grew up within about two blocks of each other in a very small, confined neighborhood in north Minneapolis. They represent a significant group, I think, of early leaders in Kaiser Permanente in southern California. They were: my cousin, Bob, that I just mentioned, and Dr. Charles Sadoff--we all grew up together as kids, and went to the same high school and junior high school and so forth. And Chuck is currently the associate medical director of our Sunset facility in Los Angeles. So three of the nine associate medical directors grew up together as kids.

Huth: Is there anything you could point to--maybe the schooling you had? Was there any special interest in the sciences in your high school, or some reason why there were so many of you who were into medicine?

Shragg: Well, there was a great motivation, and, I think, push towards education, college degrees, by our parents. The one thing they all

strove for--our parents--was that we not end up to follow in their footsteps, you might say--as tailors, or shoemakers, or whatever. They just worked in order to have us all have college degrees. Medicine was an out for us, as a potential--doctors were obviously all well-respected, and so we all strived for that.

My cousin, Bob, also has a son who is an internist with the Permanente group in Sacramento. I have a son, Bruce, who's a radiologist--he's in private practice--but he took his radiology residency at the Sunset facility. So we do have a lot of involvement with Permanente. But I was going to elaborate that probably the genesis of most of this, of this grouping of us who sort of emigrated from Minneapolis--obviously for weather reasons--and came here--I think we were all oriented to a group type of practice, the philosophical approach that Kaiser Permanente had and still has, but certainly more so in those days. It was very appealing to us.

Dr. Jack Gordon, who was the first pathologist in southern California, and who started this fabulous centralized lab, with the economies of scale, and that probably can never be duplicated anywhere else, also grew up with us. He was a couple years older than I and also from Minneapolis, Minnesota. And he--

Huth: Did you know him?

Shragg: Oh, we all grew up together. We were all friends as children.

Huth: So he was in the same neighborhood?

Shragg: Same neighborhood, same background, same schools. He was a couple of years older than I. Actually, his younger brother, George, was a classmate of mine. But our families were very close, and we all lived together--in the very same neighborhood, in a "ghetto," as a matter of fact. You could call it a ghetto. Jack came out here first and helped recruit the rest of us. So he, for me, at least, was a lead person, even though Sadoff and my cousin, Bob, antidated my arrival.

Chuck Sadoff also has a brother, Leonard Sadoff, who was younger than I, and who is also an internist with the Southern California Permanente Medical Group at Sunset Hospital. So we have the two Sadoffs, the three Shraggs, Jack Gordon, and, in addition to that, Dr. Martin--

Huth: It's almost nepotism.

Shragg: It's almost nepotism. [laughs] And in addition to that, there is Dr. Martin Schaperman who was a classmate of mine, also from the same neighborhood, who is chief of radiology at our Panorama City Hospital and has been with the organization for thirty-some years,

or close to that. And Dr. Irwin Goldenberg, a pediatrician from St. Paul, a classmate of Jack Gordon's, was, I think, the first chief of pediatrics in southern California. There's just a whole contingent of early arrivals from Minnesota.

Huth: Is that Kaiser you're talking about for Irwin Goldenberg?

Shragg: Yes, he was the first chief of pediatrics with Permanente. He came out to Fontana with Dr. Raymond Kay* and Dr. Alvin Sanborn. There were two other Minnesota people at about that same time: Dr. Ted Konig, an internist at Fontana, trained at the University of Minnesota--I don't know if he went to medical school there.*

Huth: Was there some recruiting at the University of Minnesota, that maybe brought them all here?

Shragg: Yes, Dr. Kay was led to Dr. Gordon--I don't know exactly by whom, but my cousin Bob, I think, remembers the details. There was a Dr. Paul Blanchard, who has since died, who was chief of medicine at Fontana, who also was an internist at the University of Minnesota, or trained there, and who came out here. He and Bob, my cousin, had met Dr. Kay; Dr. Kay was doing recruiting then, and he'd come up to that part of the country, and they touted him onto Dr. Gordon, who, at that time, I think, was in Omaha, having left Minneapolis. He got Dr. Gordon to come out here--

Huth: Did he have a lab there?

Shragg: He was at the University of Nebraska as a pathologist.

Huth: That's in Omaha?

Shragg: That's in Omaha. Prior to that, Dr. Gordon was in private practice at a hospital in Fort Dodge, Iowa, after he finished his training. He went on to Omaha, and then Dr. Kay recruited him to come to Los Angeles, and Jack became very involved.

Kaiser Permanente's Philosophical Appeal

Shragg: Philosophically, it was a very appealing thing to all of us from this neighborhood.

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*Raymond M. Kay, M.D., The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985-1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

Huth: Why do you think that was so? Anything from the family backgrounds, or from the parents having come from Russia, or--?

Shragg: Well, I think it was a social conscience. It was a social consciousness certainly for me and for the rest of us. It had an appeal that--here was an opportunity to practice medicine, quality medicine, without having to grasp the concern about whether the patient could afford it or not. All of us, I would say, certainly myself, my cousin, all of us--our own medical care when we were children, and our families'--was usually through the county general hospital.

Huth: Which would be similar, in a way?

Shragg: Well, it would be similar. I guess they'd call it welfare now. We never thought about it like that. We just couldn't afford anything else.

Huth: And it would be like a group practice.

Shragg: I don't know that that influenced us as much as the concerns that we had that fee-for-service practice, even then, at least good quality fee-for-service practice, was somewhat beyond the means of most of our people, people in our neighborhood and so forth. I think there was a significant element of that, in my judgment. I had been personally in practice in Elmore, Minnesota, and I was uncomfortable with having to be concerned about dunning people for money. And then, if they didn't have it, it was always a concern, not that they didn't need the care, but there was something of a personal barrier between the patient, if he couldn't afford it, and the physician.

The group practice, which this represented, and the prepayment mechanism, were really a very appealing combination of factors, I think. I'm sure that the southern California climate was also appealing to those of us from Minneapolis, but I think the philosophical-professional part of it was more important.

Huth: Would there have been a particular professor in medical school who talked about this concept? Or did it start when you were children?

Shragg: Oh, I can't say that it started when we were children. Minneapolis--Minnesota and Wisconsin were, in a sense, politically rather progressive socially--with the farm labor movements in that part of the country--

Huth: And also didn't early interest in Social Security measures begin there?

Shragg: Did they? I don't know.

Huth: I have heard that it was Hubert Humphrey of Minnesota, who's idea it was--some years before it was passed by Congress.

Shragg: Well, I think that the group practice concept flourished more in that part of the country in proportion to the population size. There was the Mayo Clinic, and there's the University of Minnesota. There was the Nicollet Clinic. There were group practices there. There was the Eitel Hospital, a hospital run by a Dr. Eitel, that was sort of a group practice model.

It was a close-knit medical community, Minneapolis was, and not far from the Mayo Clinic. Although there was always a competitiveness between the Mayo Clinic and the University of Minnesota, which I never understood. But it was a fact of life. There was the Duluth Clinic. That was 150 miles from Minneapolis. But the fact is that there were a lot of group practice models, if you will, in Minnesota. Certainly it was in contrast to the East Coast, where individuals are usually in solo private fee-for-service practice, in spite of the tremendous medical communities in the Boston and New York areas. But individual private practitioners are, by and large, individualists, rather than group-oriented.

Whether that was a factor in it, I don't know. I can only guess.

The University Medical System Model, and Prepaid Group Practice

Shragg: But for myself, personally, having a partner in this small town, I knew for sure that practicing in a very small group, all along, was not for me. I decided that medicine really did require a collective grouping, and the model that Drs. Kay, Garfield, and the other founders of our group established really was the university system. We all thought that the university system practiced the best medicine that was known. All of us were provincial enough to think that our medical schools had the best professors and practiced the best medicine. And I think that was true for all of us who had respect for our professors and teachers at the University of Minnesota. We obviously found that they practice as good, or as bad, medicine elsewhere. But nevertheless, the universities are nothing more than prepaid, salaried physician groups, hospital based, multi-specialty, where the individual physicians--at least in those days--were not concerned about whether the patient could afford it or not. Economics was not a barrier to providing good care that they felt was necessary or indicated.

The irony of this whole thing is--certainly, when I

joined Permanente, as did the other earlier doctors--the resentment and hostility that we all encountered from our colleagues in private practice.

Huth: And from the medical society.

Shragg: Right. And it was astounding when you stop to think that we trained at the same places that they did. We all trained in the universities, where, again, we did practice prepaid, comprehensive medicine without any economic barriers in a very powerful learning environment--a teaching environment. The day after most of the physicians completed their training programs, the very next day, suddenly, prepaid, hospital-based, organized group practice was an anathema to them. Only private practice fee-for-service was viewed as the very best type of practice.

Huth: Where did that come from? Was it cultural?

Shragg: Oh, I think it's cultural, I think it's economic, I think it's the American Medical Association [AMA].

The other irony is that, when we were in medical school, or residents in training, we looked down--which was equally prejudicial and equally wrong--we would look down upon solo practitioners in private practice because the cases sent to the university essentially were more difficult and problem cases, that could not be easily solved by the private practitioner. So the impression of the students was, you know, that--they used to refer to them in case presentations as the LMD. That means "local medical doctor." But the implication was "that dummy out there couldn't cope with it, and therefore was sending it to us smart people here at the university." It was really a downer--very prejudicial.

Having been on both sides of it, I can tell you that the university also makes its share of mistakes and errors and so forth. So you look down upon it when you're a resident. The minute you're through with your residency, all of a sudden you look down at the university. It's a complete 180 degree switch.

Huth: Is it almost universal?

Shragg: It's universal. And then you get into the situation where you do have the competition between the ivory tower, which is the university, and the local practitioner, and there is unfortunately antagonism and competition. It's always been that way. It's a different thing now because the economics have changed so drastically over the years.

I could never understand the doctors being against us, when we

essentially were pretty much emulating a university environment that all of us as students certainly wanted to emulate. And all of us thought, "Why, that's the best way to practice medicine--to be at the university." And the reason everybody didn't stay there was because there wasn't enough space, or they didn't pay as well as you could get in private practice and so forth. So that was always an interesting question.

University and Army Medical Service, Mayo Clinic, and Kaiser Permanente Compared

Huth: Do you think the Kaiser Permanente idea came up right after--well, I guess actually it started earlier because of Garfield's going up to the Grand Coulee Dam, and then the construction to bring water to Los Angeles from the Owen's Valley, and working to provide medical services to Kaiser workers in those areas. But it really got going after World War II, and many of the doctors who came back and were with Kaiser Permanente had returned from U.S. Army medical practice.

Shragg: That's right, yes.

Huth: And do you think there was any similarity--you were in the army, too--was there any similarity to the university practice, and the army medical service?

Shragg: Yes, the relationship of the physician with multiple discipline specialties working together, again, in a hospital setting on a military base--is a very comfortable way to practice. Now, where I was stationed, in Great Falls, Montana, we weren't particularly busy, but it was nice to be able to call in consultants, and have them at your beck and call, and available. And I liked discussing cases together, learning together, improving together, with peer review involved. Whereas, in fee-for-service solo practice that exists to a much lesser extent.

Yes, I think that helps. One of the largest health maintenance organizations [HMOs] in Minneapolis-St. Paul now is the St. Louis Park Clinic, which was started by a group of these ex-GIs who came back and finished their residency after the war. And again, they started a group in Minneapolis that is now the largest HMO in that part of the country, as a matter of fact, and an excellent medical group.

So I think there was something in the background of the culture of those areas--the political culture in the upper Midwest--that, I guess, fostered that kind of thing. There are plenty of big clinics

in the Wisconsin area, for example, the Gunderson Clinic and others that were existing then. Whether they emulated the Mayo Clinic, which was one of the original ones, I don't know, but it's possible.

Huth: The Mayo Clinic was similar too, wasn't it? It isn't attached to a university, is it? But is it similar to the university type?

Shragg: Well, it was a very high-powered, high class, practicing and training program, with groups of great physicians working together in a--. It wasn't prepaid, but from the physician's standpoint, I guess, they were essentially salaried. It wasn't exactly salaried, and I don't really know what their salary program was, and nobody else does, as a matter of fact. It's been a very highly kept secret. But they were just good doctors, multidisciplined, working together in a hospital in an outpatient setting. The only difference between us and them, in terms of the organization, is really the prepayment mechanism. So there are some similarities.

Family, Medical Career Goals, and Personal Philosophy

Huth: Going back to your family background, you said that your father was from Russia. Were some of the parents of these others that became doctors from the same area in Russia? Did they come to this country together? Was it a group of people that knew each other?

Shragg: No, not in Russia. They may not have known each other, but they came from the same area, I believe, and they had much in common.

Huth: But some of them found each other here?

Shragg: Yes, they found they had much in common politically, philosophically, ethnically, economically.

Huth: And your mother, too, had come from that area?

Shragg: Yes, my mother, and my wife, Yetta--my wife's parents also came from Eastern Europe. She had a brother who was a physician, but her father was a furrier. She and I were married in '44. We have two children, one of whom is a physician.

Huth: Were you married in Minneapolis?

Shragg: Yes, married in Minneapolis. [laughs]

Huth: It's a Minneapolis story, isn't it! What was your wife's maiden name?

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Shragg: Licht. It's German. Her mother actually had come from Austria or Poland—you never knew what the borders were. Every other year the borders would change, depending on the nature of the wars that were occurring.

Huth: Is Shragg a Russian name?

Shragg: Yes, as I said, it was Shragowitz, and then we of our generation shortened it to Shragg. We just added a "g" to it.

Huth: Dr. Kay's name is Russian or Polish, if I remember correctly.* He also shortened his name.

Shragg: I believe Kaydeski, or something like that. His family has a longer history in the U.S.A. than mine.

Huth: But that was Russian, or perhaps Polish.

Shragg: Yes. His ancestry, as far as it existed in America, really goes back almost to the post-Civil War era, I understand. His grandparents--Dr. Kay is eighty-one--came to this country, and then moved to Marshall, Texas, and that ought to put them back into the late 1800s when they emigrated there. Where they came from, I don't know, but he and I have talked about it--

Huth: Poland, I think.

Shragg: From Poland, yes.

Huth: Kasminsky, I think.

Shragg: Kasminsky? That might be it. He was born here, and I assume his parents were, but I don't really know for sure. His ancestry in America goes back much longer than mine.

Huth: But in the communities in Russia that these people came from, is it possible that there was some similar type of medicine practiced, or something like it?

Shragg: Not to my knowledge.

Huth: Okay, I'm trying to find some underlying reason.

Shragg: I think the reason was just simply education, and fostering education and learning. I don't know where we got the idea of going into medicine.

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*Kay interview, Regional Oral History Office.

Huth: And then, was it an idealistic idea too, in a way--to benefit the people that you would be serving?

Shragg: Yes, I think there's a humanitarian aspect to it. We went into it because it was a way to make a reasonable living. As a matter of fact, at which I have exceeded far beyond my expectations as a child. And there definitely was a humanitarian aspect to it. I don't want to be corny about it--we didn't go into it just to save humanity; we went into it for personal reasons. But that was certainly an ingredient, I think, in terms of the background and social consciousness of my parents, and certainly of my uncles, my cousin, Bob, and his family. So I just don't think there's any question about it.

Huth: How many brothers and sisters did your father have? Was he from a large family?

Shragg: Yes, my father had two older brothers, one older sister, two younger brothers, and a younger sister. One sister remained in Russia, and, as far as we know, perished during World War II. One of my uncles emigrated to Argentina, and the rest came to Minneapolis.

[tape interruption]

Shragg: I mentioned my son, Bruce, and I have a daughter.

Huth: That's right, we didn't talk about your children. I think we should do that first.

Shragg: I have a daughter, Eve Lynn, who is thirty-nine, married, no children, and my wife, Yetta. We've been married forty-two years, and--

Huth: How did you meet your wife?

Shragg: Well, we were actually childhood sweethearts when we were in junior high school.

Huth: Were you in the same neighborhood?

Shragg: Right, same neighborhood, and we actually went to the same junior high school, although not to the same grade school.

Huth: Same class?

Shragg: In junior high school and high school, right. So we were going together since we were about fourteen or fifteen years of age. We were going together six years before we got married.

Huth: What year did you marry?

Shragg: On August 27, 1944.

Huth: That would have been during World War II.

Shragg: Right. I was a medical student. I'd just finished my freshman year in medical school, and we got married. Our daughter was born when I was an intern, and she was born at the general hospital where I was born. So we're really into this Minneapolis thing. The irony is that, even though my wife delivered there and was delivered by a very dear friend of ours, who was also a professor of obstetrics, and was delivered there because I was an intern, we--I guess, literally could have qualified for welfare assistance even though I was then an intern.

Huth: The pay was kind of low in those days.

Shragg: $50 a month and all we could eat. Our son was born in Blue Earth, Minnesota.

Huth: Where is that?

Shragg: That's in southern Minnesota. We were living in Elmore, Minnesota from 1948 to 1951. That's a small farm town where I was in general practice for three years. So Bruce was born in Blue Earth, Minnesota. That's where we had this hospital, such as it was. It was really an old home that was sort of converted into a local hospital. It really was an old, two-story home, which now is a nursing home.

Huth: Were you the first people to practice in it after it was converted?

Shragg: Oh, no.

Huth: It had been there a while?

Shragg: Yes, it had been there, and it had been used by the old doctors there for years. Just as I left that area they had built a new thirty-two-bed hospital--I mean a real, honest-to-god hospital--and they've subsequently increased the size, or even built a new one since January 1951, when I left.

The hospital was such that the beds were literally in what was previously either the living room or dining room in the old house. The kitchen, of course, served as the dietary department. I think we had five or six patients in it at any one time--or ten at the most. The operating room was what used to be a bedroom. When we practiced there and we delivered babies, or someone else did any surgery--we didn't do any surgery--we would then have to carry the patient from the operating table or the delivery table, to the room

because there were no corridors through which a patient transport cart or a litter could be manipulated with it wheels. But everything worked out okay.

Huth: Did you become very strong at that time?

Shragg: I actually got a slipped disk as a young man, just carrying somebody upstairs. My office was on the second floor, upstairs over a bank building and a butcher shop. We had to carry people upstairs because we didn't have elevators in that town. It's the same town that Fritz Mondale, the former U.S. vice-president, came from. In fact, he left that town just as I arrived, but he was a local hero even then, as a young man.

Huth: Hubert Humphrey was mentioned earlier in connection with social security.

Shragg: He didn't initiate the concept of social security.

Huth: Well, he was one of the big pushers behind it. Before it was passed, he was talking about it. I think it was as a college professor.

Shragg: Wasn't social security passed in the '30s, when Franklin D. Roosevelt was president? Hubert certainly was one of the social leaders of Congress and that era.

I also remember Harold Stassen, who was from Minnesota, and he was the perennial Republican nominee for president. He was considered very liberal-minded, even as a Republican. So there was a long tradition in history that came from Minnesota-Wisconsin. Governor Robert La Follette was a very progressive man on social issues in those days, too.

Huth: What else can you tell me about your daughter?

Shragg: She's an artist who's married to a businessman. They also live here in Los Angeles.

Huth: And your son, Bruce?

Shragg: He's a radiologist. He also got some of his training in radiology at the Kaiser hospital in Los Angeles.

Huth: And is he married?

Shragg: No.

Huth: And you just have two children?

Shragg: We just have two children, correct.

Huth: Where's he practicing now?

Shragg: In Canoga Park, California. That's in the [San Fernando] Valley. He's in a group radiologic practice.

Huth: We didn't ask any questions about grandparents. Did they have any influence on your life and future decisions?

Shragg: I don't think so. No, I only knew my grandmothers briefly. One grandmother died when I was five, and the other one lived with us when she came over to this country. My mother's mother lived with us until about the early '40s, and then she moved to live with another daughter--because my mother had died a few years earlier. My mother died in 1939, and then my grandmother left, and died shortly thereafter. I would guess about '44, 1944, or '45. No, I don't think they were--not in that sense.

Huth: Not really close to you?

Shragg: Well, we were close, but not in any way of influence. They were just from the old country, and elderly, and just hard workers. My paternal grandmother died when I was four or five. I just remember her casually, not in any depth.

Huth: I think this would be a good place to stop.

Shragg: Okay. [tape off]

Religious Life, and Social Conscience
[Interview 2: April 28, 1986]##

Huth: Doctor Shragg, will you please tell me whether or not religion played an important part in your life in your early years and throughout your life?

Shragg: Yes, it played an important part. I'm Jewish, and we were raised Orthodox Jewish. Although I don't consider myself Orthodox as the moment, I have been involved with Jewish affairs all my life. I think that it probably is a factor, to the extent that there was always a social conscience that was involved in our home, in our environment, our upbringing--politically, philosophically. And probably it was a factor in terms of my overall background, and regarding getting involved in a program such as was at Kaiser Permanente.

The backgrounds of most of those whom I mentioned from Minneapolis were not identical, certainly not in terms of the

religious background, but just in terms of the environment and the social philosophies that were prevalent in our neighborhood they probably were similar. My parents, as well as those of some of the others--Dr. Gordon in particular, and my cousin, were involved in various organizations that had social philosophies that, I think, go along with this type of program. There was concern for those that perhaps could not afford medical care, and with this program aiming to provide that for at least the middle or low-middle income group, I think that was philosophically an attractive proposition.

Huth: I thought perhaps that was true from some of the things that you told me the other day. Did you go on any vacations in your early years? You mentioned that so much of your life was in Minneapolis, Minnesota. Did you stay within the state for your vacations, or did you travel at all in your early years?

Shragg: No, we didn't do any traveling. I didn't do any traveling actually until after I became a physician. Whatever traveling or vacations we had were really close to home, not very extensive, and certainly did not involve any extensive travel. I don't recall doing any significant traveling until I was in the service. Then I was in Denver, Colorado, and then back at Minneapolis for most of my service. At that time, going to medical school, and then subsequently into the Air Force, I did more traveling to the training camps in Alabama and an assignment in Great Falls, Montana. And then, as we moved to California, we did some vacationing after I was in medical practice. But there was not much travel before I was in practice.

Marriage and Children

Huth: During your high school and college years, what was your wife-to-be doing? What were her special interests, and did she work or go to college? What did she study, if she did go to college?

Shragg: When I went to the university, she took business courses, and her other interests I would guess would be music and athletics. She worked while I went to school.

Huth: Where did she work?

Shragg: She worked in various retail outlets as a saleswoman. She worked for a dentist in his office as an assistant, and after our first child was born in 1947, she was essentially a homemaker, a housewife.

Huth: And has she stayed with that through the years?

Shragg: Yes, retaining those same interests.

Huth: Did she ever play an instrument?

Shragg: Well, we both played the violin, and she played the piano. That's one way we met--in orchestra. And she and I both played the violin in junior high school. I'm sure it was a catalyst in getting to know one another.

Huth: And did you continue to play in orchestras after junior high?

Shragg: No. I played in senior high school until my mother died, and then after that I started to work, and I did not pursue it further.

Huth: Did she stay in the orchestra?

Shragg: No, she didn't either. She really did it for fun, not as a serious student once we got out of high school.

Huth: How about sports? Has she continued her interest in sport activities?

Shragg: Well, she was always a good swimmer and tennis player. Her major activity now is golfing. She always liked it and was a good athlete--for a woman in those days.

Huth: And has she continued her interest in music as an appreciator?

Shragg: Well, just as a bystander, as an appreciator, right. She plays the piano at home, but just for her own fun.

Huth: What can you tell me about your decision to marry, and to marry at the time you married? Did it have anything to do with any wartime activities?

Shragg: I don't think so, no, because I was rather fortunate, and she and I had been going together for five or six years, since we were in junior and senior high school. We just fell in love and just got married--that's all. It had nothing to do with any wartime activities because I really was not involved in going overseas, or anything like that--certainly not at that time. We just got married.

Huth: And it was at what point in your medical studies?

Shragg: I had finished my first year in medical school, so I was going into my sophomore year when we were married.

Huth: When were your children born; what years were they born?

Shragg: My daughter, Eve Lynn, was born on October 12, 1947--

Huth: What is her married name?

Shragg: Her married name is Sperling.

Huth: And your son's full name?

Shragg: Bruce Alan Shragg. He was born on June 27, 1950.

Huth: Can you tell me something about your daughter, and about your son-in-law? Just a few words about what she's like, and what her interests are.

Shragg: Well, she's beautiful physically and otherwise. She's very outgoing. Her primary interest is art, and she studied art at UCLA. She has a degree in art and art history, and she has done a lot of painting--not professionally, but just for her own interest. We think, of course, that she does well--as do many others. She's very well-liked wherever she has been involved with other people. She has worked in the Suicide Prevention Center as a volunteer.

Huth: Is that a social consciousness that she maybe inherited from you and your wife somewhere along the way?

Shragg: Well, I hope so. In high school she was the girl of the year, and she won some awards like that. Her husband—

Huth: Where were you when she went to school? Where were you located?

Shragg: We were here in Los Angeles. She went to Inglewood High, to Longbeach State, and to UCLA. Her husband, now my son-in-law, Arnie, is the co-owner of a very successful business--the Globe Tire Company, with many outlets. He's a very bright, aggressive businessman—aggressive in a good sense. He's a UCLA graduate.

Huth: Did they meet at UCLA?

Shragg: Well, they met through our synagogue, as a matter of fact. That was her first exposure, because they lived in the same neighborhood, and he's a couple of years older than she, so they were not in the same classes together. They were married on August 30, 1969.

Huth: Did they meet while they were students?

Shragg: No, they were not students. Arnie's father died when he was a young man, and he subsequently went into the business with his brother and another friend. They met through a mutual friend who actually fixed them up on a date at some event, and that's how they got together. They live in West Los Angeles in Pacific Palisades.

Huth: And there are no children?

Shragg: No children.

Huth: How about your son, can you describe him in a few words?

Shragg: Yes. My son Bruce is a very terrific guy! [laughs]

Huth: [laughs] That's nice for parents to think that about their children.

Shragg: Well, he's very well-liked; he's a talented young man who likes music. In fact, he was thinking of going into music, and decided to go into medicine instead. He has always been involved with music--percussion, drum instruments--while he was in college.

Huth: Where did he go to college?

Shragg: He went to UCLA as an undergraduate. He then went to Guadalajara, Mexico, to get into medicine. And after two years there, he was accepted as a transferee to Hahnemann Medical College in Philadelphia. When he completed his training there--I think it was 1976 or '77--he then began his internship and specialty at the Kaiser Foundation Hospital in Los Angeles and went into radiology.

Huth: Did he specialize in the internship? Was that where he began to specialize?

Shragg: The internship was a general internship in internal medicine, and then he decided to go into radiology. After completing that, he took a fellowship at the Los Angeles County Medical Center in CAT scanning. Then he went into practice with a group of radiologists in Canoga Park.

Huth: Is he still there?

Shragg: Yes, he's still with that group. He's been there three or four years.

Huth: I think you told me he is not married.

Shragg: He is not married, no. He's gone into writing, taking courses in script-writing for TV and movies--more of an avocation. He's also back into piano playing.

Huth: Well, that's good that we got some of that background. It's just possible they may want to read this oral history, and they'll find themselves in it.

Recalling World War II Experiences

Huth: I think we need just a little bit more about your Army Air Force career, and I want to ask you--this is before you were in the army--where you were on December 7, 1941?

Shragg: On December 7, 1941, I was standing in front of the campus theatre at about noon on Sunday in an usher's uniform. I was working as an usher at the campus theatre.

Huth: What was your reaction?

Shragg: Well, I was stunned--

Huth: Were you of the age that could have been drafted?

Shragg: I was seventeen years old at the time.

Huth: Too young.

Shragg: Well, too young--I was already in college in December because I finished high school a little earlier than my other classmates. And so in June of '41 I started college immediately because I had nothing to do in the daytime, since I was working evenings and weekends.

Huth: Were you going full-time?

Shragg: I was going full-time. So in December I'd already had six months of college. I was I guess a little over seventeen years old. So yes, it would affect me, obviously, as I became eighteen years old. But I guess I was just stunned. Just a sudden thing, not knowing what to believe, what to anticipate. But I remember exactly where I was that day.

Huth: And it was a while after that before you went into the service.

Shragg: Well, I registered when I was eighteen--I suppose. I don't remember specifically, but I must have, and I think my college probably deferred my going into the service.

I don't remember what draft number I had at the time--

Huth: Were you already in premed training at that time?

Shragg: Yes.

Huth: And could it also have been because you were in premed? Would that have deferred the draft?

Shragg: Yes. Oh, I think so. It was just very fortunate for me. And subsequently, when I finished my premed training, my medical school class had not yet begun, so the army sent me to Fitzsimmon's Army Hospital near Denver in 1943, for the few months before my medical school started, which was January 1944.

Huth: So that's how you happened to go to Denver.

Shragg: So they essentially drafted me and assigned me there, even though I only had three or four months to go before my medical school classes began.

Huth: But you were drafted at that time, or were you already in the services?

Shragg: Well, I had a number, and I was assigned. They drafted me to go there because our medical class had not yet started. Other contemporaries of mine had not yet finished all their premed training, so they didn't have this three or four month hiatus.

Huth: What did you go there to do? Was it some special duty, or you were just sort of marking time?

Shragg: I think part of it was marking time, but they gave us some basic training. We were assigned to the medical corps as premed and predental students. There were a lot of others throughout the country that were assigned there, and all of us were to be sent back to our respective medical and dental schools.

Huth: Did they keep you busy?

Shragg: Yes, except it was really a lark in many ways because all of us expected it, and we were fortunate that we knew we were going back to medical school, not to the war.

Huth: What kind of a facility was it? Were you in barracks?

Shragg: Oh, it was regular army barracks on a regular medical base--Fitzsimmon's Army Hospital was a very large military general hospital, a very first-class hospital outside of Denver, and still is a major referral center.

Huth: My father died there after World War I.

Shragg: At Fitzsimmon's? It was a first-class hospital. We were not doing medicine, of course, because we were not yet trained, but they put us through some basic training and army discipline--things like that. Nothing very constructive, I might say.

Medical School, the Minnesota Social Environment, and the Prepaid Practice Concept, 1941-1947

Huth: How did you happen to go to the University of Minnesota?

Shragg: It was cheaper.

Huth: Oh, it was because it was cheaper. Was it also because you were already a resident living there?

Shragg: Right, we lived there.

Huth: And did you live at home while you went there?

Shragg: Oh, sure. Well, in premed I lived at home. In medical school they put us into the men's dormitory.

Huth: Were you still in premed right after you came back from Fitzsimmon's Army Hospital?

Shragg: No, I was in premed from June 1941 until 1943, when I had completed all my basic requirements. And then the army sent me to Fitzsimmon's Army Hospital--that was premed--for three months. When we left Fitzsimmon's, I went directly into medical school in January of 1944. We were then housed in what was a men's dormitory in peace time, but it was taken over by the military to house the army students.

Huth: And were there students other than those in medical school, too?

Shragg: There were others. I think they had engineering students. We were in what they called the ASTP (the Armed Services Training Program). There were other specialties that were also housed there--I think engineers were housed there and so forth.

Huth: When did you first decide to go into medicine? When was that decision made?

Shragg: I think we were sort of always geared as children to believe that being a doctor was a good profession. That's about the best I can tell you.

Huth: So it wasn't a late decision?

Shragg: I don't think so. In junior high school it was medicine and engineering. As a junior hign school student in the orchestra, I thought that being a musical conductor would be a nice profession. That was sort of a fantasy at the time.

Shragg: As we got older, I think medicine became clearer. I had an older cousin and other friends who went into medicine. But becoming a professional, whether it was medicine, law, engineering, or whatever, was a very basic desire of most of the people that I grew up with. We saw it as a means to get out from under the economic despair--although I didn't know I was poor at the time--of our parents, who were not professionals in the educational sense. Some were tradesmen, and others were just common laborers and so forth.

Huth: What about other professions? Did some of them go into law, too?

Shragg: Law, engineering. A lot of them went into business.

Huth: But were all of them looking for some goal, some future goal?

Shragg: Right. In north Minneapolis, or at least in our neighborhood--I'm sure it's true of all sorts of other underprivileged neighborhoods--either you became a professional, or you went to jail. It was an all or none sort of thing. I know it's an exaggeration because a lot of people did not become professionals, and they did fine and grew up honest and straightforward.

Huth: Were there any courses in college that you wish you could have taken, but didn't have time to take? Was there some other thing out there that you thought would have been great to study?

Shragg: Oh, yes, very much so. I think that I missed not being exposed enough to the general arts and literature. Everything was focussed on just premed courses, and just getting through with the basics. Part of that was accelerated by virtue of the war, so that we were in a twelve-month-a-year curriculum.

Huth: All summer, too?

Shragg: Right, so we were in twelve months a year, which was fine, because once I got into ASTP, financially I didn't have to be as concerned about tuition. And so I was very fortunate.

Huth: Were you able to make up for not being able to do that, later?

Shragg: Well, I think I've lost a lot in the sense of not being exposed to that in my earlier years. Just as an aside--once we got settled, I was able to do some reading on the side, but not in any in-depth sense. That, I really regret--wish I could do over again.

Huth: I know that on some of the college campuses there are medical fraternities. Was there such a thing at the University of Minnesota, and did you belong to it?

Shragg: I belonged to a medical fraternity, Phi Delta Epsilon.

Huth: What was it like?

Shragg: Well, we had no house. It was not a fraternity in the traditional sense. It was just a grouping of physicians and medical students who would get together periodically, and the older physicians who belonged were very helpful and supportive. But it was strictly a professional organization--with some social functions--but it wasn't the typical fraternity or sorority house type of atmosphere or environment, which I personally deplored then and still deplore as an elitist type of thing.

Huth: Did either of your children belong to a fraternity or sorority?

Shragg: No, they had no desire to, and I don't know what I would have done if they wanted to. We might have had some disagreements philosophically. But I'm not sure we would have.

It was a Jewish fraternity because the other medical fraternities excluded Jews, and we had no blacks at the time, and only a few females in our medical school classes. I think things have changed dramatically since those days.

Huth: Does that fraternity still exist?

Shragg: Well, the fraternity still exists, and my understanding--I'm not active in it as an alumnus--is that, you know, it is not exclusive. We were never exclusive, although obviously there were not many non-Jewish people who elected to join our fraternity. And we didn't have a house, or any of the other amenities that perhaps might be attractive to out-of-town people. For example--people who lived out of town who might want to live on campus. But many of the other medical professional fraternities--my understanding is--accept people of all races and backgrounds now.

Remarkable Colleagues and Medical Instruction

Huth: Were there any professors that stand out as having been special, or who inspired you especially?

Shragg: Yes, there are a lot of them. Especially in the Department of Physiology, there were a lot of very liberal-thinking, socially-conscious people in medical school that were good role models. They were bright, they were fair, they were tolerant. And then there were some clinical people--some physicians that were in practice who

were clinical associates at the university. Probably the outstanding professor--and there were many outstanding professors--was Dr. Leo Rigler, as a person, as a humanitarian, and also as a scholar and scientist.

Huth: What did he teach?

Shragg: He was head of the Department of Radiology. A very warm, caring person. But there were a lot of them. Dr. Owen Wangensteen, who was an austere person, also was a very caring person who was head of the Department of Surgery. [shows a photo] This is Dr. Maurice Visscher, who was the head of the Department of Physiology. This is a picture of Dr. Wangensteen and Dr. Visscher.

Huth: Would it be possible to get a copy of that?

Shragg: Oh, sure.

Huth: That would be an interesting addition to this history.

Shragg: Dr. Cecil Watson, who has also since died, was chief of medicine.

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Shragg: There's a Dr. Victor Lorber and a Dr. Nate Lifson, who were in the Department of Physiology. They were particularly friendly and easy to be with as students versus our professors.

Huth: They were just easy to talk to?

Shragg: Yes, they were easy to talk to, and they were friendly. There were several who were then residents who became professors in their field of surgery: One was Dr. K. Alvin Merendino--

Huth: Was he a resident then?

Shragg: He was a resident, I think, when I was a medical student, or at least he had just completed his residency. He subsequently became professor and head of surgery at the University of Washington. Dr. David State, who subsequently became department head of surgery at Albert Einstein Medical School [New York City], and at UCLA Harbor General Hospital. He was a resident or a senior resident if not a staff person in surgery, at the time that I was a student. And they were easy to deal with, and talk to and so forth. Some were not as approachable as these two in particular.

Dr. Ivan Baronofsky was also a surgeon.

Huth: Was he one of your teachers, or professors?

Shragg: They were instructors, they were not professors yet--in that day.

Huth: And also a resident at the same time?

Shragg: They'd probably finished their residency. They were in training, but probably instructors at the time.

Huth: But more accessible than some of the others.

Shragg: Yes, they were our immediate teachers. They were in Dr. Wangensteen's department.

And Dr. Richard Varco, a very brilliant surgeon, who was then a professor of surgery. He was a little bit more distant as a student, but subsequently, when I became a resident in surgery, was much more accessible and easy to talk to and get along with--someone that I admired as a very capable, caring person.

Huth: Were some of these special role models that you looked to?

Shragg: I don't think so because I did not want to be a surgeon when I finished medical school. That was not my goal.

I intended to become an internist, as a matter of fact. It was only after I was in general practice for three years that I met another man, who probably was as influential in my career as anybody: a Dr. Harry Neel. He was a surgeon that I used to refer my cases to in Albert Lea, Minnesota. The initial impression of surgeons versus internists was that surgeons were more arrogant, unfeeling, egotistical perhaps, and maybe less caring--in spite of the fact that I've named a few people that I liked a lot, who were then our instructors in surgery. That reminds me of a Dr. George Aagaard, who was an internist, who was a tremendous person. There were other internists, too, but I've been concentrating on surgery for the last thirty years or so.

But getting back to Dr. Neel--I saw him as a very nice, kind, soft-spoken, caring person, who was also competent. When I decided to leave general practice and go into a specialty--even though surgery was only one of several considerations--my exposure to him perhaps influenced me as much as anything to accept a residency in surgery, as well as counseling by Dr. State and Dr. Baronofsky, who recommended that I try the program at the Minneapolis Veterans Hospital, where Dr. Lyle Hay was the chief of surgery.

It was all part of the University of Minnesota program, but it was geared more towards training surgeons for clinical practice rather than academic practice--research and publishing--which was not my interest. And Dr. Hay, I must say, is one of the nicest, most caring people I've ever known, and also an extremely competent, soft-spoken, and a very important person--one of the nicest persons that crossed my path.

Dr. Donald Ferguson replaced Dr. Hay as chief of that department during my residency, and he was a different personality. He was also one who I think of as being very caring, but much more rigid, more strict, dogmatic, more academically inclined—I can't get the right words—but really much more rigid and strict in his approach. He was not as approachable, or warm as Dr. Hay, but somebody that I respected then, and in retrospect, respect even more now as someone who would never ask you to do anything that he himself would not do. That's always been a guiding principle for me, personally. I would never hesitate to call him in the middle of the night that he wouldn't respond to help.

The same would be true for Dr. Hay, of course, but again, the personality was just totally different.

Huth: That's a great recommendation for a person, to be able to say that about them.

Shragg: Well, he probably was not as giving emotionally as Dr. Hay would be, or as tolerant perhaps as Dr. Hay. He was a more strict disciplinarian.

Huth: Perhaps he had a reason, do you think, for being that way?

Shragg: Oh, I don't know. Well, you know, we're all different people, different human beings and backgrounds, and I can't get into any psychoanalytic discussion about what makes people tick differently. But we had some anxiety about him when he replaced Dr. Hay because Hay was such a warm, friendly--you know, sit-down-with-the-students person.

Huth: When he was replaced, was it because he retired?

Shragg: No, he moved to another position. He took over the position of residency training at a private hospital in Minneapolis.

Dr. Hay's philosophical approach was probably that your family is first and medicine is second. I think the attitude of some of the other professors as--that, you know, medicine is the most important thing in the whole world and a family's okay, but it's sort of secondary. Dr. Hay told me personally--he said, "When you come here to work, you can work hard, but remember your family comes first." And that is not really a position that many outstanding professors, who have made contributions to humanity and progress in science and so forth, felt. I think that said something about him as a man.

So, you know, it takes all kinds. And I think that's probably why he left, because his mission in life was not to publish or perish, as it is in most academic centers. They all had their importance to me.

I think the one thing that's within the Permanente Medical Group in southern California, that's one of it's great strengths, is that all the chiefs of service that I've ever been associated with, and know of in other areas, are practicing physicians. And they do, and are responsible for, as many onerous jobs or activities within their respective departments as any other doctor, and therefore they are good chiefs of service.

Huth: So the chiefs of service are actually doing another job on top?

Shragg: Well, they can't use their role as a chief to excuse themselves from, say, overnight work, or taking care of certain kinds of patients. They may do fewer clinical duties because they may have to spend some time with their administrative roles, but none of them--at least none that I've been associated with--would ever expect to do anything less just because they're chief.

Perhaps that's one reason why I became chief of surgery-- because my predecessor, the one who hired me, did try to take advantage of his position as a chief in Harbor City. It resulted in a demoralized department.

Huth: Going back to your medical school days--which is where we were when I asked you about your professors--when you graduated from medical school, was that an event that was very important to your family? Did your family come to the graduation in 1947?

Shragg: Oh, sure.

Huth: Was it considered a milestone in a way?

Shragg: Yes. I'm the oldest of four brothers, so that represented a milestone, although my cousin, Bob, had graduated a little before me, and our families were so close it was almost like one family. It was a major milestone.

Huth: Looking back in the family history that took place before that, would that have been considered quite an achievement?

Shragg: Oh, no question about it.

Huth: Do you credit the type of training that you got at the University of Minnesota, and the residencies that were associated with it, with some of your later success? I'm referring to the quality of it, or the things that happened to you there? Perhaps you were able to compare it in some way, with what you saw in connection with other people coming from other places?

Shragg: Well, we were pretty close-knit at the university. There was very little outside exposure, that is, outside the University of

Minnesota environment. It was different than it is now. Now some medical students have opportunities to travel to other universities or hospitals for some exposure to different ways of doing things. We didn't have it then--at least. It it was available, I wasn't aware of it. For most of my training, of course, we were in the military, so we were pretty well confined to that environment.

Huth: I'm wondering if you can look back and say that it perhaps had something to do with what happened to you later?

Shragg: Well, I think that certain people, in terms of--again, I keep coming back to the, as I perceived it, caring attitude. Dr. Rigler, probably, as a figure, as a role model, was just a unique personality in the university as well as internationally. As a humanitarian he was involved in all sorts of social functions and activities. Many of these people that I mentioned to you were also very early supporters of Hubert Humphrey: Drs. Visener, Lorber, Lifson, and I would guess Rigler--I'm not positive. But certainly the physiologists were very actively involved. And the University of Minnesota was a great base for Hubert Humphrey.

Then there was a clinical professor of obstetrics, Dr. Milton Abramson, whom I became very close to. He was a few years older than I, but he was in our fraternity, and was a very competent, but humorous, caring obstetrician in practice. Those people were very supportive when it came to considerations of going into, say, Kaiser Permanente--that kind of program--because in Minneapolis there was the Group Health Association, which was trying to get off the ground in a prepaid mode. There, as here, most of the fee-for-service physicians were tremendously opposed to that kind of medical care program.

These people, Abramson in particular, and others, saw it only as a real positive way to practice.

Huth: And were they active in their own medical associations?

Shragg: Yes.

Huth: So they had, in the prepaid idea, the support of the medical associations?

Shragg: No, no, not the medical associations. All organized medicine was opposed to this, no matter where.

Huth: But they could be members of it.

Shragg: Oh, sure. But they, as individuals--for example, when it came to considering an option of working in a prepaid setting--were very, very supportive of the idea, in contrast to most private practitioners, who were tremendouly opposed to it. Again, it

probably speaks to the Minnesota influence that we talked about the other day, where the idea of group practice models, such as the Mayo Clinic and other kinds of clinics that we've mentioned—was not a foreign consideration in that part of the country, in contrast to the East Coast, for example. The West Coast was also group oriented.

But the prepaid concept, which was sort of new, and, again, with the Group Health Association—people trying to put together groups of physicians to care for employed members on a prepaid basis were supportive of the idea.

Huth: Did they talk about it, so that you were aware of the idea in those days?

Shragg: No, it was just known because Minneapolis and St. Paul are really cities with a very small, close-knit group of medical centers.

Huth: Isn't it also the major metropolitan area in the state? There's not much other metropolitan area other than that—of a city type, really, in the state.

Shragg: That's correct.

Huth: So for politicians, too, the major base would be that part of the state.

Shragg: That's right. Now the metropolitan area there--Minneapolis-St. Paul--has the highest percentage of members enrolled in prepaid group practice of anyplace in the country--percentage-wise, for the population.

I am told that probably the first prepaid group practice in the U.S.A. was at Two Harbors, Minnesota. This was a small harbor town on Lake Superior, near Duluth, Minnesota. It handled the shipping of iron ore from the Mesabi Range. It antedated the Ross Loos Medical Group, which preceded the Kaiser Permanente Health Plan. If my memory is correct, the doctors in the Two Harbors Medical Group were thought of as "communists" by organized medicine.

Internship at Hennepin County General Hospital, Minneapolis, 1947-1948

Huth: What places did you consider for your internship? Did you consider going outside of Minneapolis at all, was there ever any thought of that—or did you decide to stay?

Shragg: Well, I thought about it only because there's always a yearning to

travel and to go elsewhere. But I was married. Hennepin County General Hospital in Minneapolis was considered a first-class, rotating internship, so I applied there. I think I applied elsewhere, but I'm not certain. I think probably to [Los Angeles] County.

Huth: What is a rotating internship?

Shragg: Well, they don't have them these days. A rotating internship was one where every year of your internship you would rotate between different services: internal medicine, surgery, pediatrics, radiology and so forth. In contrast to what is unfortunate now, that medical students in their junior year must make a commitment to a professional track in one or many disciplines. So that if they are going into internal medicine, for example, they almost have to make a decision in their junior year. And then their internship is strictly an internal medicine internship--just an exclusive, specialty-oriented program. It is just tragic, in my judgment, because medical students are in no way qualified to make such a decision--

Huth: They could make the wrong decision.

Shragg: And I see it all the time in the interviewing of hundreds of doctors and seeing what their reactions are here in our group. Many are very unhappy with their basic selection.

Huth: Is it difficult for them to go back and change later?

Shragg: Sure.

Huth: They've already invested so much time and money in it?

Shragg: Correct. It takes a certain effort to say you don't want to be an internist anymore and you want to become an anaesthesiologist, or whatever. But I find a number of them that really regret it. The ones that regret it the least are those who have had either a military experience, or, in my case, general practice experience, and then make a decision to go into training after they've been exposed to a variety of types of practices. They, I think, are the most content.

Huth: Is there any reason why they've switched back?

Shragg: The medical schools have done it. I think they've gone crazy.

Huth: Is it done because it is considered more efficient for the schools to plan ahead, or is there some other reason for this practice?

Shragg: I don't know why they do it; I just know it's wrong--in my heart I know it's wrong. How can one make a decision in their junior year

when they haven't even, in many cases, been exposed to a variety of other kinds of disciplines: dermatology, anaesthesiology and so forth? As many students go through these services they get turned on by that respective clerkship, or medical field that they may be exposed to at that time. And it's unfair to do that. I think it results in poor doctors, in my judgment.

Private Medical Practice in Elmore, Minnesota

Huth: Why did you choose Elmore, Minnesota as your first place to practice? Why did you go there? Was it close to Minneapolis-St. Paul, or was it your only job offer? Did you get other job offers?

Shragg: Well, there weren't any job offers. I just sought out practice opportunities as I could find them in various publications that would advertise places that would look for physicians in small towns. As I said earlier, I had expected and planned to be an internist. When I finished my internship in the good residency programs all the positions were taken up by returning veterans-- all over. Many of my friends in school, instead of taking the residency, stayed on as postgraduate students in physiology, and bacteriology, and other kinds of disciplines, awaiting an opportunity to apply for and be accepted as a resident in whatever discipline they wanted.

I considered possibly going into general practice in the Minneapolis area. Again, another friend of mine who had been in general practice talked me out of it because, at the time, it was difficult if not impossible for a Jewish physician to get on the staff of a hospital. That was before the Sinai Hospital was built in Minneapolis. Once that was built, then the opportunities opened up in that hospital and in other hospitals.

At the time, this friend of mine who is a psychiatrist now, suggested that--

Huth: What friend is this?

Shragg: His name is Martin Gordon. He was in general practice in Minneapolis at the time. When he got an interesting case he had to turn it over to an older physician who had staff privileges. That was demeaning at the time. Here we were, already licensed, and with the authority to practice medicine, and then we were compromised on now to practice by virtue of this prejudice.

Huth: Hospital closure. [laughs]

Shragg: Hospital closure, right.

So I felt the hell with it. I would try general practice because I wasn't 100 percent certain, and I thought, "Well, I'll try it, and if I like it, fine. I don't have to be a specialist." I was married and had a child. So I looked for a small town--and that, again, was by Minneapolis standards. As a big city person from the upper Midwest, there was always a fantasy about being in a small town.

Huth: That was because you grew up in a city.

Shragg: Yes, it is on your mind when you grow up in a city. So it was an opportunity. In retrospect, I don't know how I did it because it's certainly not my basic style of living.

So we were looking. And one place that was looking for a doctor was Phillip, South Dakota, in which I would have been the only physician in the whole county. You know, it's a sparsely populated county. But it was an opportunity to make a few bucks and also get some experience and exposure, and that was my objective--to try to get some money and--

Huth: And you decided against South Dakota. Why did you make that decision?

Shragg: Well, it was about four hundred miles away. It was in the next state--just west.

Then a classmate of mine, Troy Rollins--he's an important person in my career.

Huth: Was that in medical school?

Shragg: Yes, he and I were classmates. And we were friendly--not very close, necessarily--and he came from Blue Earth, Minnesota. He was married to Mary Jane, who came from Elmore, Minnesota. Troy had, as an intern, agreed to go to Elmore, Minnesota, and take over the practice of a doctor, Arno Sommers, who had been there some twenty years, and who left to go into radiology at the Scott White Clinic in Temple, Texas.

Troy had agreed to take over, and wanted to go back home and be a physician, but he didn't want to practice alone. And he had arranged with a fraternity brother of his--also a classmate of ours--Bill [William] McCluskay, to come down as an associate. And sort of at the last minute Bill decided against going there, and Troy--we were interns together, too--knowing that I was looking around, suggested that I perhaps consider Elmore. And I did, and it was to our liking, and it was a fascinating experience.

Huth: You were there three years?

Shragg: Yes, three years.

Huth: And what did your wife think of Elmore as a place to live?

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Shragg: Well, she was involved in the social scene there. But the town had only eight hundred to nine hundred people, so it was a tiny, tiny town. She found it more difficult than I did because I was very busy and tied up. She and I had one child. And it was totally foreign to both of us; we were the only Jews in the whole town, and there were some interesting prejudicial comments. Although I must say that the hostility between the Lutherans and the Catholics was just as pervasive and probably more so, because most of the people were concerned more with their day to day prejudices than with a single Jew. They most probably never encountered a Jew on a frequent basis. It was such a surprise to me to see this. It was part of my maturing, to experience other people's concerns, interactions, interrelationships, etcetera, that I had never been exposed to before.

I did well, I think I was respected and liked.

Huth: And your practice prospered?

Shragg: It prospered? Yes, it prospered.

Huth: Was it a group practice?

Shragg: Just Troy and I. We got along very well together.

Huth: Did he have a specialty?

Shragg: No, we were both in general practice. He went to Oregon, which was interesting because when I decided to leave and go into a specialty he really pooh-poohed it, as did most of the general practice colleagues in the surrounding towns that we got to know very well. They were sort of hostile to specialists, I guess. Then he subsequently left after I did, and became a dermatologist.

We did everything there. We didn't do any surgery because we didn't feel that we were qualified.

Huth: What did you do with surgical cases? Was there a surgeon there?

Shragg: Well, we referred them to Dr. Neel in Albert Lea, for one thing. And we did refer a lot of cases to Minneapolis, and to Mason City, Iowa, or Mankato, Minnesota. They were larger towns with specialists there. It was just a three-year, fascinating experience for me.

Huth: Small town life.

Shragg: Small town life was interesting, but not to our liking—at least not that small. And that really was a major turning point for me to decide not to go into internal medicine. Other options were being considered, and surgery became available. And I've been pleased, and have had no regrets on that.

Residency, and Surgery Specialty: Veteran's Administration and Military Service, 1951-1957

Huth: Was it difficult to find a residency in surgery? You had to go back for further training, didn't you?

Shragg: That's right. I went back in '51 and started my residency at the Minneapolis VA [Veteran's Administration] Hospital, and then left that same year for two years in the Air Force during the Korean War, then returned to finish a total of four years of residency at the VA Hospital from 1953 to 1957. When I finished there I came to southern California.

Huth: How did you happen to go into the Army Air Force in October, '53? Was there some special reason for doing that?

Shragg: Well, since we in our class were trained by the U.S. Armed Forces, and since the war [World War II] ended before we were finished with our medical school, we had an obligation to fulfill our responsibility to the commitment of this country during the Korean War. When the Korean War came up and they needed doctors, we were therefore the first class to be called upon.

You see, when the class ahead of ours finished medical school, they were obligated to go and serve two years as medical officers. My class did not have that--we had the requirement, but then it ceased as soon as World War II was over. So when the Korean War conflict began, then, of course, we were the first medical officers to be called back into service. Then we had a choice, and I just--I don't know why--I just picked the Air Force.

Huth: No special reason?

Shragg: No special reason.

Huth: Where were you stationed?

Shragg: Well, I was six weeks at Maxwell Air Force Base for my basic training as a medical officer.

Huth: And where was that located?

Shragg: In Montgomery, Alabama. And then I was assigned to the Great Falls Air Force Base, [Great Falls,] Montana, and I was there for the duration of my obligation.

Huth: Never got to Korea?

Shragg: I never got to Korea. I was one fortunate person in both wars.

Huth: What was your rank?

Shragg: Captain.

Huth: And how did the army grade medical officers? Did you have a grade?

Shragg: I was graded as a general practitioner because I'd only had nine months of surgical training.

Huth: They didn't have the A, B, C, D grading?

Shragg: They had it. I forget what my letter was. But I was a general medical officer.

Huth: And was your family with you at all of those places that you were assigned?

Shragg: Well, not in Alabama, but once I was settled in Montana they joined me, yes.

Huth: And it was still your daughter and your wife at that time?

Shragg: And Bruce. He was born in 1950.

Recalling Army Air Force Service at Great Falls, Montana

Huth: Does anything in particular stand out in those two years that you served, to October 1953, concerning your medical experiences? As to the people you met--did any long-term friendships come out of that?

Shragg: Well, we met some very lovely people, we developed some long-term friendships, and--we don't see them often--but we're sort of in contact, with Christmas cards and that sort of thing.

Huth: What about the medical experience itself?

Shragg: It was a very relaxed, easy two years. Probably the two best years of our lives was then.

Huth: Group practice?

Shragg: It was group practice, no question about it. But it's interesting the number of acquaintances that I met there, who, when I got through and was joining Permanente, were really down on it. The most vociferous one was Dr. John Busman, who's now a well-known pediatrician in Portland, Oregon, who is himself now organizing some kind of a prepaid program [laughs].

Huth: To compete with Kaiser there?

Shragg: That's right, sure is. In fact, there was an article in one of our throw-away papers that we see periodically where his name was mentioned. And I couldn't help but send a little dig at him about how he's become converted, born-again.

Huth: Did he respond to it?

Shragg: Yes, he responded. We really haven't seen each other in twenty-some years. It's just, you know--But there's a Dr. Francis Healy and his wife, Grace, who are just delightful people in the Bay Area. He was very active in the California Medical Association, and he is still a fee-for-service entrepreneur.

Huth: But you knew him there.

Shragg: Yes, we got to be very close in the Air Force and we still are.

Huth: Which place?

Shragg: In Great Falls.

Huth: Can you talk about these things?

Shragg: Oh, yes. I'm really very, very fond of him. We're total opposites--he's Catholic, and I'm Jewish, and he's--

Huth: Where does he practice now?

Shragg: In Burlingame. And he's fee-for-service, and I'm prepaid. But he is such a nice man, and his wife, Grace, and his kids are just terrific people. And we can talk about anything--religion, medicine--and we respect one another's opinions. It's just a terrific relationship.

Huth: Do you get to see him very often?

Shragg: Yes, I would say maybe on an average of once a year--we bump into each other, or something like that. He's very understanding, but he's got his own agenda and so do I.

Huth: He still really believes in it.

Shragg: Oh, sure.

Huth: Even with all the changes that have taken place.

Shragg: Well, he's always been a tolerant person. We can have different opinions. But some people are so fanatic about their own respective opinions that they don't tolerate anybody else's ideas. And Frank sure does, as far as I'm concerned. Terrific guy.

Huth: So the people stand out more than anything, the people you met there, rather than--

Shragg: Yes, the medicine was nothing, it was just another relaxed two years. We never knew why they assigned us there, because the day that I arrived in Great Falls, Montana, with my orders, the medical administrative officer didn't even expect me. He wasn't even aware of it, and said, "Gee, we don't need any more doctors, but as long as you're here, let's do this and this."

Huth: Did you have time to see the country? That's great country up there, isn't it?

Shragg: That's what we did. We did a lot of traveling through Yellowstone and Glacier Park, and Banff, and Lake Louise [both in Canada]. So it was, again, a nice two-year respite for us, having been in medical school, and residency, and practice.

Huth: Was your daughter old enough to be going to school there?

Shragg: Oh, sure. Yes, she went to school in Montana. She was four in 1951 when we moved there.

Thoughts on a Future in California

Huth: Did you have any ideas then about what you were going to do? At that time had you decided to go to California to join Kaiser Permanente?

Shragg: No, not at that time.

Huth: You went back to residency after that, didn't you? Had you been thinking about your future, and what you were going to do after the residency?

Shragg: Well, Permanente was not in the cards at that time. California certainly was because my wife had gone to California to work after she got out of high school.

Huth: Oh, where did she go to?

Shragg: She just came out here with a bunch of friends and they all went to work out here in Los Angeles.

Huth: So she knew the area.

Shragg: She knew the area, and as a matter of fact, when we got married, she said, "Someday we're going to California." And she was right. I'm sure that was a major factor, because she had been here and she liked it.

Huth: How long had she lived and worked here?

Shragg: Just, maybe, a few months to a year. She came out here, and then I was at Fitzsimmon's Army Hospital, and—I forget how long she was out in California. I'd say, probably, six to twelve months. Not a whole lot longer. But out of high school she came, and fell in love with it.

Huth: That was adventurous of her to do that.

Shragg: Yes, she came out with a bunch of girl friends from Minneapolis, and her sister. They all lived in an apartment house together, and they all worked and had a lot of fun.

So I would guess that was the major turning point, as far as a decision to ultimately come to California. And then when we were in Elmore, Minnesota, we came out to California on a vacation because by that time her parents had moved out here--her parents and her brother. So we came out for a visit, and it was my first exposure to California.

Huth: So did her parents hear about it from her and then decide to come?

Shragg: No, I think they were elderly, and they were going to come out here to a warmer climate. That I'm sure was another factor in our coming to California.

The Permanente thing didn't really come into play until, I would say maybe 1955--when Dr. Jack Gordon had already joined, my cousin had joined, and Jack came back to Minneapolis several times. We had talked, and that was an attractive type of practice. So it was about that time that the idea of Permanente really was being considered.

Huth: I want to ask you a couple of questions about your residency before we go too much into that.

Shragg: Okay, sure.

Huth: We talked about some of the people during your residency that were important to you later. Can you tell me anything else about the residency experience, whether anything special stands out in those years? That was a period of about four years--well, a little less: October 1953 to January 1957. That was when you were in surgery residency?

Shragg: I was in surgical residency, correct. There were just some personal friends. There were also co-residents with me.

Huth: I have a question about the experiences themselves, as surgical experiences. Were there any unusual things that happened, or some personal growth-type times for you?

Shragg: Well, it was hard work. We were on call about every third night. That did not seem to bother me; I guess that was an expected and accepted norm during those years. It was a very intense time. We were fortunate to the extent that, having been in practice, I was able to accumulate some money so that we bought a nice little GI-type home, and were perhaps a little bit more comfortable for that than perhaps some of the other co-residents who had just gone into training right out of medical school.

So that turned out to be a real plus, having been in practice. Plus, I think—

Huth: You were older than some of the others there too, weren't you?

Shragg: Yes, a couple of years older, three or four years older. And I think having had the experience of general practice was important for me, and I think important for my training--because I had that experience as well.

Huth Did you ever have any administrative-type duties during that time?

Shragg: No, nothing more than just being chief resident, through which you become involved in some administrative delegating of responsibilities. That was, I think, for six months. But nothing other than anybody else would get through a normal residency--a pyramid system of training.

II SURGEON, CHIEF OF SURGERY, AND ASSOCIATE MEDICAL DIRECTOR FOR SOUTHERN CALIFORNIA KAISER PERMANENTE, 1957-LATE 1980s

The Decision to Join Kaiser Permanente

Huth: Before you joined Kaiser Permanente were you recruited—did someone come and talk to you?

Snragg: Yes, they did. Yes, Jack Gordon came to Minneapolis and talked to a lot of us. Again, I had had this tie with my cousin, Bob, who had already joined here, and Chuck Sadoff. But Jack Gordon was probably the most important person in that regard, who in talking to me was able to commit to me through Dr. Raymond Kay--I had never met Dr. Kay--a surgical position before I even came out here.

So I had that available to me, although, when I came out to southern California, I did look around and kind of check into other options or opportunities, like private practice--but not very seriously.

Huth: Did you come out to talk to people here before the decision?

Shragg: Well, I moved out here, and I met Dr. Kay and Dr. Buck Wallin in Harbor City, and they accepted me. I hadn't yet committed myself. I had gone up to northern California where I met with Frank Healy, as a matter of fact. He had already been in practice as an internist, and he and I laugh about it these days because he said, "Geez, Harry, there are so many surgeons that have moved into the Peninsula and into the Bay Area"--which was obviously a very attractive place to live--"I don't know how you're going to make it. It's going to be tough." And he and I laugh about it because they all did well, and he felt that I could have joined, and probably done just as well as anybody. But that was a factor, although southern California was more attractive.

Huth: You mentioned Dr. Wallin and Dr. Kay. We want to be sure to get first names. And you called him Dr. Wallin--

Shragg: It's Ira Wallin. We call him Buck.

Huth: Why is he called Buck?

Shragg: I don't know, maybe because he was a great big guy. But his real name is Ira Oscar Wallin. He's an important person in my life at Permanente. He hired me, and we've been very close, although he's a maverick--as I mentioned--in many respects. He's a daring and innovative person in the sense that he's willing to try things. And it's part of a problem in that, I think, unfortunately this does not exist as much within our organization anymore, probably because we're so large. And that's tragic because that's the creative, innovative part of our whole program.

Huth: We'll talk some more about Dr. Wallin a little later, when we talk about relationships with other people. You'll have a chance to tell me about him.

So you were aware of the controversy about the medical program at the time that these people came to talk to you, were you? Did you know it was a controversial thing that you were considering?

Shragg: Oh, yes. I knew about it. You know, I belonged to the county society, and the Minnesota state society, and many, many--

Huth: Did somebody try to talk you out of it? Did anybody talk to you about it?

Shragg: None of my friends, no. When I spoke to other friends of mine who were in private practice, they were all respectful of the people--the types of the physicians, and the quality of the physicians within the program. Whereas the county society, the organized medicine, was very much opposed to it, and they said it was on philosophical grounds. But I never believed them. They were always opposed to it on the basis of their pocketbooks. They were always concerned about the competition. I don't think they could care less what kind of political or social philosophy we had. They were all selfishly oriented to their own pocketbooks.

But the academic centers--UCLA [University of California at Los Angeles], and USC [University of Southern California], and so forth--were very much on our side. They were very supportive.

Huth: USC also?

Shragg: Oh, USC in particular, more so even than UCLA, perhaps. That was because of our doctors at that time--Dr. Kay, Dr. Frederick Scharles, Dr. Herman Weiner, Dr. John Winkley and there was also a

Dr. James Fenimore Cooper--

Huth: There was? Is he related to the famous author?

Shragg: Yes, he is. He was head of Urology. Dr. T. Hart Baker--he was head of Ob-Gyn [Obstetrics-Gynecology]. Dr. Jack Hallatt, Dr. Leonard Buck. All these people were on the academic staffs of these various academic institutions.

Huth: Either at UCLA or at USC?

Shragg: Most of them, yes. And some out at--well, I don't know if they're out at Loma Linda [Medical School], or not, but out at Fontana [Kaiser Permanente Hospital].

So the academic centers were very supportive or our type of program. After all, they were sort of a role model for us. The individual entrepreneurs and the organized medicine in the county were very much opposed.

Huth: How about your wife? What did she think of the idea?

Shragg: She was very supportive of it.

Huth: She wanted to come to California?

Shragg: Well, California for one thing, but the idea that I could have a planned life--Yetta having been the wife of a general practitioner, where I was really literally on call twenty-four hours a day, seven days a week, and in residency. The idea of being an individual, solo practitioner--she was not very happy with that prospect. Neither was I. The idea of a planned life--in some measure; some nights and weekends would be my own, or mine and hers, and her family's--was a very, very attractive part of the whole program.

Expectations and Experiences at Harbor City Hospital, San Pedro

Huth: What did you expect to find, when you first came? Did you have plenty of advance knowledge because your cousin was already here? Did you have any expectations of what it was going to be like?

Shragg: I just expected it to be like a super-residency program, with colleagues of mine who were philosophically inclined to similar objectives--in terms of how to practice and who to take care of. The people I met at Harbor City were just--as a group--

Huth: Was that where you went, to Harbor City?

Shragg: Originally I went to Harbor City, the Harbor City Hospital. I thought I'd be at Los Angeles--

Huth: Is Harbor City at Long Beach?

Shragg: Well, it's in the Long Beach area, adjacent to Long Beach near San Pedro.

Originally, I thought I'd be at the Los Angeles facility with Jack Gordon, and Charley Sadoff, and Bob, my cousin. We, as children--well, certainly when we got into medical school--we always had a fantasy--my cousin and I, and Jack, and his brother, George, who at one time was associated with Permanente, and then left--we all sort of had our little fantasy that maybe someday we would have our own clinic. That may have been one reason why I went into surgery--because they went into internal medicine, and non-surgical fields. So we always had sort of a dream to do that. And in some measure, at least, I think we've fulfilled part of that with Permanente.

But anyway, I thought I'd be at Los Angeles-I just assumed that--but the position was in Harbor City, and Dr. Kay promised me that when a position opened up at the Sunset Boulevard hospital [Kaiser Foundation Hospital in Los Angeles] I could transfer to Dr. John Winkley's service. But when that opportunity came, I preferred to stay at Harbor City.

Huth: And you'd been there how long?

Shragg: I think I'd been there a year or two. I just liked the smallness of it, and I had already made friends, and it wasn't that inconvenient.

Huth: Where were you living then?

Shragg: I was living in Westchester, near the [Los Angeles] airport. I had chosen that because I had expected to move to Sunset, and it was sort of halfway between Harbor City and Los Angeles. And it proved to be important later in my going to West Los Angeles. It helped me because I lived in the area. So that was probably another factor.

And then the people that I met in Harbor City--the doctors--were just good people, very competent and well-trained. There were some exceptions, of course, like in anything. But as a group--I think I was the twentieth doctor at Harbor City--so it was a relatively small group by our standards today. So you got to know everybody. You knew all the doctors, you knew all the people, you knew all the personnel.

Huth: Patients too?

Shragg: Well, patients too, yes. So it was a very close-knit group, and

that was an attractive part of it, and it's part of the problem now--that we are so large that there is some depersonalization, which is unfortunate. And it takes away some of the fun of practicing in the group.

Huth: Was it very different? How was it different from your private practice, or previous experiences?

Shragg: It was not much different than the residency because we really were working all day and all night and responsible for our own patients, and then on weekends and nights we were supportive of each other and covered for each other, so we could free each other up for our other personal needs and activities.

Huth: So it was similar to the residency.

Shragg: Very similar to a residency. In fact, it's been characterized--working here as a physician, at least in our hospital where we don't have an internship or a residency program--that we really are super-residents in the sense that staff people in an academic center can delegate to the residents, or other flunkeys, to do some of the basic what we call scut-work, you know, minor, trivial things. And we can't do that here as full-time staff people--we do it ourselves. Although the nurses have come a long way over the years to do many of the things, like starting intravenouses, and catheterizations, and nasogastric tubes--those we had to do ourselves as a resident, and now it's the nurse's job.

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Shragg: And then I had some free time to myself, and when I was not on call and the telephone rang, I knew it wasn't for me. And that was very important for me and my wife because I'm very compulsive about phones, and whenever it would ring, I would jump. That was before we had beepers, and I hate to carry a beeper for that reason. It really is an intrusion on our privacy.

So I could plan my vacations and not have to worry about my patients, and my wife could count on me for certain social activities, whether it was going to a concert, or eating a meal, or parties.

Huth: Your children could count on you more?

Shragg: My children could count on me, and when I was on call they knew I was on call. And when I wasn't, they knew I wasn't.

Huth: So you could plan your life.

Shragg: Exactly.

Problems in Harbor City's Group Medical Care Environment

Huth: Was there anything that surprised you that you didn't expect to find there in Harbor City--that was a real surprise for you?

Shragg: Well, yes, I would say the major surprise is, well, part of it is personalities, egos, the interaction within large groups, with problems of egos, and jealousies, and different motivation--differences in degrees of motivation of one person to another--and philosophical differences. And many of them were rather supportive and good. But some were destructive and were unfortunate. But on the other hand—and I can see it better now, with another twenty-plus years of other exposures to human frailties--is that there is no difference between that and in other group environments.

The army, I guess, wasn't quite as bad becauae there wasn't the pressure. And in the residencies it was not as big a problem, in retrospect, because we all had goals in mind that meant that in three or four years we would be separated. But here was an environment where conceivably you'd be together for twenty-thirty years, in a whole career. And that's the major problem. It is just people.

Huth: Is it because of looking forward to advancement? Is that what causes the problem--who's going to get to where, or what caused it?

Shragg: Part of it is that, but I don't think that's a major part of it. Everybody wants to be in on the action. Everybody wants to be a decision maker, and many people can't accept having other people make decisions for them. In a large group that has to be delegated and relegated to another forum, whether it's a board of directors, or chief of service.

I learned very quickly, and it was very disappointing to me when I became chief of surgery after I'd been there two years, approximately. We were a very small group, and the moment--I didn't realize this, and I was hurt by it--the moment I became a chief, even though the day before I wasn't a chief--the moment I had a title people started treating me differently. I didn't like that.

Huth: Do you know why that happened?

Shragg: Sure, because now I was one of "them" instead of one of "us"--kind of a phenomenon. I consider myself a socially gregarious, outgoing, friendly, you know, kind of guy, and a hard worker--put in as much or more of my share of effort. And as soon as I became a chief and became part of the administrative team, I'd walk into the surgeon's lounge, for example--where before we would joke, and kid, and talk,

and yak, and gossip, and bitch, and groan, and all the other things that human beings do when they get into groups--and the minute I'd walk in there they'd shut up.

Huth: Silence?

Shragg: Silence, yes. Because now all of a sudden, gee, here's this new chief, and he's now listening, and they'd better be careful what they say in front of me.

Huth: Was it a painful time?

Shragg: Painful, very painful. Because these were basically people that I considered very close, personal friends.

Huth: You were still doing all of your same work as a surgeon.

Shragg: Oh, sure, there wasn't any slacking off in my efforts. It wasn't as if they were suddenly saying I was goofing off because I was a chief. As I said, I think the reason I became a chief is that my predecessor was doing that and taking advantage of that.

Huth: Do you want to name this person?

Shragg: Yes, Peter Eastman. I don't care. It's not libelous, is it?

Huth: No. Not a thing wrong with it.

Shragg: But Peter was a strange man. Very, very bright. Socially terrific guy, loved boats--in fact he loved boats more than medicine or anything else. He was intellectually dishonest in many ways. He was a writer, a very clever man, but he really took advantage of his position. Many of us had to make up for his human frailties.

Huth: Do you want to say in what way he took advantage of his position?

Shragg: Well, one of the things that he did that led to his downfall, in essence, was that frequently he was supposed to be doing administrative time--now this is what Dr. Wallin told me--and whenever we had to get hold of him--on a Saturday, for example, he was supposed to be the administrator--we were seeing patients, or working, and if you had to get hold of him you had to call the Coast Guard to contact him out in the ocean because he was out there sailing.

Huth: Contact him on his boat?

Shragg: Yes, and that's not administrative, by my book. You know, that was an example.

The internists--the other people who would refer cases to him--were very reluctant to do so, and as a result the other three or four of us had to bear the brunt of that. Part of it was his personality and his lack of thoroughness. There was an arrogance about him.

Huth: What did the people who had to cover for him do about that? Was it generally known?

Shragg: They didn't replace him. He stayed on as a non-chief, unfortunately.

Huth: But someone with authority found out that he wasn't working properly.

Shragg: Yes, Dr. Wallin terminated him as chief. You see, he was a partner by then in our partnership--which has too much security, in my judgment. They terminated him, but they couldn't terminate him as a partner without a formal vote, which people were reluctant to do in those days. So I was saddled with having—

Huth: So you had to work with him after that?

Shragg: That was tough; that was very difficult. That was an experience that I couldn't have foreseen in medical school.

Huth: It must have been tough for him, too, in a way. Did he stay on?

Shragg: He stayed on. I asked Dr. Wallin when he offered me the position as chief what was going to happen to Pete. And he said, "Well, with his ego and his arrogance, and with his thia and that, he's not going to stick around." Much to our chagrin, he stayed—he had a good deal. He had a tenured position, in essence, and that really wreaked havoc with a lot of us emotionally.

Huth: Is he still there?

Shragg: He's retired now. And again, socially a very charming man. I can give you an example—I think we could talk for ages--but the nurses didn't like him. Whenever he came into the operating room, they sort of had to watch what they said or did and so forth. They didn't like him. I'm generalizing—there were plenty of times that he was fun to be with, so I don't want to epitomize him as a real ogre because he really wasn't. But one of the nurses snuck into the doctors' lounge and tied some bells on his operating shoes. Now, obviously he was aware of them when he put them on because they would tinkle a lot. But he chose not to take them off, and of course when he walked in the operating room you could hear him coming through, and we kind of snickered and laughed.

I thought that was a real put-down on the type of person he was. He turned around--he was somewhat of a writer--and he wrote a little short story about it. Of course, he came out the hero in the short story, and sent it in to Reader's Digest and they gave him, as I recall $250. So he took something negative and he made something positive out of it, and even made some money out of it. And the nurses were tremendously upset about the turn of events. It was just that sort of thing. He could never admit that, when he had a complication--which all of us have--that he was in any way responsible or involved in the complication. And many of us would have to take care of his complications on weekends when we would make rounds to see his patients. It was just unfortunate.

Huth: You had to cover for him.

Shragg: Yes. Now, we all covered for each other, but we would call him and he would come back--and we'd wonder why he didn't take care of it on Friday instead of waiting until Saturday, when somebody else would possibly take care of it, or something like that. But that was just the nature of the person.

Those were the sorts of experiences that, once you get out of training, people just don't guess at happening. Life just isn't that way. And it wasn't unique to us. This happens, I think, in any kind of a group environment when we have to work together. And that's one of our major challenges.

Huth: The people, and getting them to work together?

Shragg: Right, that's tough. That's the major problem.

Administration and Medical Staff Recruitment

Huth: Was the hospital at the Harbor facility comparable to those you had worked in?

Shragg: That was much smaller. When I joined it was fifty-six beds--very tiny.

Huth: Was the staffing up to what it should be?

Shragg: The staffing was okay for that size hospital. The quality of the physicians was, as a rule, superb. I could be proud of just about all of them.

Huth: Was your salary comparable to what you would have had if you'd been in private practice?

Shragg: Well, I don't think so. All of us fantasize that if we were out in practice we would make a lot more money. My salary when I joined was $1,100 a month, and that involved--

Huth: What was the year?

Shragg: 1957. And that involved being on call. If I got called back, I didn't get any extra pay.

Huth: And you were a surgeon?

Shragg: I was a surgeon. But that didn't bother us. I mean, I just expected that. As a surgeon I was on call day and night--at least to the extent that we shared calls. But nowadays, if you work extra hours you get extra compensation, which I think is a good benefit. But that was not a major issue--salary was not an enormous issue with us. It was the way of practice. We enjoyed it--the cameraderie--in spite of its problems.

The lesson that we learned too late, which a lot of younger chiefs still aren't able to cope with, is that the selection of people for partnership is the most important responsibility of the chiefs and the partners. Tragically, that means that somebody has to be critical of somebody else and say, "I don't want you, I don't like you, you're no good," or whatever negative implications there are in making such a judgment. Doctors as a group, as do other groups, talk glibly about peer review, but haven't got the guts to really exercise it, unfortunately.

Huth: You don't see it exercised, even now?

Shragg: Oh, I see it exercised by a few people, and I consider myself one of those. I've always tried--and I've made my share of mistakes. But there are some people in this group now that twenty-five years ago I remember, Dr. Wallin wanted desperately, as area medical director, not to have as a partner, and he was pressured by others to keep them on. In retrospect, Dr. Wallin was right, and I've had that experience myself--I've seen it in other parts of our group.

Nowadays it's easier because there are plenty of doctors available in most departments--good ones. In those days it was difficult to recruit, but I always felt we were always better off working short-handed with good people and compatible people, rather than having just some warm bodies, just because you thought they would help you. They always made things worse, more aggravating, with poorer care. And I think that's the major job of a medical director and a chief--to be critical as hell about who you select for your department, and who you make partner, because we have too much tenure. I think we, in the last few years, have done better because of the pressures. But I see new, young chiefs who, when it comes to assessing the first two years and it's time to make a

decision on a doctor, haven't got the guts to say--they always use the phrase, and it's just a cop out--that once they become a partner, with the security they'll become better. It never happens, never! In fact, if anything, it gets worse. They're basically not a group person.

License to Practice, and Non-Acceptance by the Medical Society

Huth: When you went to Harbor, did you take an examination for the California medical license?

Shragg: No, I got my license through reciprocity with the state of Minnesota. At that time, if you got a license in Minnesota, you could just by reciprocity, within ten years of getting your Minnesota license, get a license in California.

Huth: Was it true of all states?

Shragg: Most states. Well, some states were easier than others. It was difficult to get a license in Florida--we couldn't get it by reciprocity with Minnesota. But most of them pretty much reciprocated. So I took out a license in 1948 because, even though I was still practicing in Elmore, Minnesota, California was on the horizon.

Huth: You already knew. Did you join the local, and California, and AMA groups, or were you already a transfer member from Minnesota?

Shragg: No. I could have transferred, but I chose not to. First of all, I think, they hated our guts. So I wasn't about to give dues to the enemy, so to speak.

Huth: But there wasn't any attempt to keep you out. It was because you chose not to?

Shragg: I never applied.

Huth: So you don't really know for sure.

Shragg: No. I belong now, but that's because of the whole change in environment--only because they've been wooing us. And in the last couple of years Dr. Frank Murray [medical director, Southern California Region] has been willing to pay for a few memberships in the LA county society. So I belong simply because the medical group is paying for it. They've been wooing us to become more involved, and have been much more accepting.

Huth: When did you join?

Los Angeles County Medical Asso

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1925 WILSHIRE BOULEVARD
LOS ANGELES 5, CALIFORNIA
DUnkirk 7-7175

July 28, 1953

This is the mo
notice ever se
the Los Angele
Medical associ
must have repl
of the members

Dear Doctor:

As you well know, there has been a great deal of controversy concerning the Kaiser Foundation, formerly known as Permanente. Points have been raised as to whether this is really a corporation practicing medicine, whether the "captive" patients of the plan forced to join by their union is good for the welfare of the people, whether the patients receive adequate medical care, whether it is proper for a layman to control physicians, etc. The Los Angeles County Medical Association must have factual information on this subject. I assure you this is most important to doctor and patient alike.

Please completely fill in the enclosed questionnaire; if a letter would be better, by all means write one. Send any information you have, no matter how inconsequential you may think it is. You will not be quoted on the information you submit; all questionnaires and letters will be destroyed as soon as statistics have been compiled.

Your reply is urgently requested.

Sincerely yours,

Paul D. Foster

Paul D. Foster, M.D.
President

P.S. This is your chance to help your County Medical Association, please reply immediately.

Shragg: I think it was two years ago, about 1984. But that's because the group as a whole has sponsored about one hundred memberships, not everybody. A few years ago the board of directors of the LA county society approached our board of directors, appealing for us to join, get more involved. And right after that the president of the county [society], Dr. Ed Zalta, who is now trying to develop a prepaid group, wrote the most castigating, insulting, hostile article as an editorial--right after he came to us, wooing us--hostile as hell about Kaiser Permanente, and other kinds of "socialized" medicine.

Huth: Where did the article appear?

Shragg: It was in the LA county journal, about three or four years ago. That might be something you could get hold of.

Huth: Perhaps I should try to find it in the library.

Shragg: I would say maybe it's a little longer than that because I think Dr. Baker was still medical director. So it must have been about six years ago.

Huth: But he had just been here, trying to get you to join. Was it because you were resisting joining?

Shragg: No, he probably had the article on ready--he was just a two-faced guy. He was president of the LA county society, and he was not a friend of ours, to put it very kindly. Now he's trying to go into prepaid medicine as the most repressive type of organization that I've heard described, where he watches every doctor like a hawk—how much they order and how much they spend. And in his group he kicks them out if he thinks they order too much or abuse it.

Huth: It sounds like he's in a management position.

Shragg: Oh, he is. With the criticism that he leveled against us about controlling doctors' lives, the guy is just a two-faced character, in my judgment.

Special Physicians with Similar Goals

Huth: Please tell me about the people you dealt with when you first joined Kaiser and you were at the Harbor City Hospital. Dr. Raymond Kay was the medical director of the Southern California Permanente Medical Group when you arrived. What sort of relationship did you as a surgeon have with him? When did you first meet him? And what did you think about Dr. Kay at that time--from your point of view?

Shragg: At that time, and for many years thereafter, Dr. Kay met or interviewed just about anyone who was accepted into the medical group--and I met with him in his office. I was just impressed with his honesty and straight-forwardness. He was gentle and sincere, obviously somebody who was imbued with the whole philosophy of the program, from a physician's point of view, in particular, and especially from the patient's point of view. I was very impressed with him. I'd been alerted to what kind of man he was by Dr. Gordon and others. They certainly characterized him as I did, and felt an allegiance to him, as I did—for what he stood for--and what he meant to the group. There was no question but that he was going to get the job done, one way or the other. Time was never any obstacle for him, if it meant doing something for the program--he was 150 percent committed to the program, and also very people oriented. That was, I would say, my initial impression.

Huth: We'll have a chance to talk about him a little more later on.

Who were the people that you met when you first joined Kaiser Permanente? Did you meet any of the people in northern California at that time, or was that much later?

Shragg: No, I didn't meet any of them at the beginning. I met some of them later. There were other people that stand out at Harbor City that I met—besides Dr. Wallin. But he was the one I became quite close to, and very fond of, and admired as a person who was creative, innovative, and daring—in the sense of wanting to try different things. The status quo was always something that bothered him. He was always progressive in his thinking, and willing to go out on a limb.

Probably my very closest friend from Harbor City days was Dr. Jay Belsky, who subsequently became chief of medicine. He was an internist at the time, and we were all the same age. He subsequently became chief of medicine, and he also replaced me as associate medical director when I left for West Los Angeles. He's one of the finest, nicest, caring people and doctors that I've had the good fortune to know.

The others were Dr. Sidney Sharzer, who was chief of Ob-Gyn at Harbor City, and who also transferred subsequently to West Los Angeles. The same things that I can say about Belsky I attribute to Sid. He was also a very positive force in the program, and one of the most unselfish people when it comes to working for and within the guidelines, rules, regulations, and needs of the program.

Then there is Dr. Raleigh Bledsoe, who also remains a very close, personal friend of ours. He joined in 1952 as a radiologist, and he was the first black physician within the Kaiser Permanente program, in all of the entities--to the best of my knowledge, certainly in southern California.

Huth: You think, possibly, in the whole system?

Shragg: Yes, I think so. Raleigh was probably, as a diagnostic radiologist, as fine a radiologist as I've ever seen and known. Those who have met with him would corroborate that, I believe. He was always on the cutting edge of radiology, a constant student, a teacher, a kind man--whom anybody you knew would be proud to know. He was a withdrawn, shy man, and he was always concerned whether he was doing a good job.

Huth: Is he still here?

Shragg: Yes, he's still here. He's an ex-partner just by virtue of his age--he's sixty-six--and he is still here.

Huth: Still working, though?

Shragg: Yes. He's been ill the last couple of months, but has now recovered enough so he'll probably come back to work part time. He's just a giant in the field of radiology, in my judgment-- very active in the radiologic-political scene organizationally, especially with the National Medical Association, which is the black physicians' medical association.

He is well-known and well-respected among his peers. There was a story that went out about Dr. Bledsoe, in terms of the early days--and I heard this second-hand, so I can't personally speak to it--that when he joined, Henry Kaiser, Sr. had some anxiety about a black physician in the group, but that the support that he got from Dr. Wallin, Dr. Gordon, and others, was such, that if Henry Kaiser was going to make an issue of it he would have to deal with a lot of these doctors who were ready to quit if anything significant happened. Which is kind of an interesting commentary on what subsequently happened with all of the affirmative action involvement and so forth, so that there was still some residual, significant prejudice, allegedly.

Huth: Some other people, I think, talked about that.

Shragg: Did they? I know that Dr. Gordon and Dr. Wallin were ready to quit the medical group--that's what I was told by them--that if, in any way, Henry Kaiser interfered with the responsibility and rights of the medical group to hire physicians who they deemed to be worthy of belonging to the medical group. I'm not sure if Dr. Bledsoe was aware of that, frankly, but that's an interesting sideline.

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Huth: If he reads the oral history, he'll find out about it--and there are a number of other things he'll find out about.

Shragg: Well, he and I are really very, very close, personally and socially, so I think we're a mutual admiration society--between the two of us.

Nevertheless, he's really a unique person, I think, and certainly in terms of his excellence, he's obviously a fabulous role model for many other black physicians who subsequently joined the medical group. I suppose he can be considered the "Jackie Robinson" of Kaiser Permanente

Huth: Has he progressed into any of the administrative jobs?

Shragg: Well, he was chief and instrumental in planning the department. On the educational front, he was always on the staff at various academic institutions and an excellent representative.

As a chief of radiology, and just as a leader amongst the radiologists, that was his main involvement. He asked to come with me to West Los Angeles because he also lived in the general area, closer to here, and he was the first person that I wanted. I'm delighted that he came with me to West Los Angeles from Harbor City.

And there were a lot of other good people at Harbor City, including Lynn Solomon, who was a surgeon and orthopedist. Just a very kind, nice man, and his wife, who themselves had some personal misfortune with the death of a child from meningitis, and a daughter who grew up to be a beautiful woman who became deaf as a result of the same meningitis. They kept their equanimity, and they were also recently retired.

Then there was Dr. Bill Fawell, an internist, who was there when I joined; Dr. James Roorda, another internist that I worked with in the early years, and Dr. Ed Blair, who was an ophthalmologist. He joined just after I did. And probably one of the nicest, most committed people is Dr. Walter Cohn, who was the first chief of pediatrics and also a leader in the early years. He, Dr. Wallin, and Dr. Solomon were the three original physicians who started a little group in Harbor City in an upstairs office above a furniture store. They were the first three doctors in the Harbor City area.

After Fontana, which was the first group in southern California, the next group that started was actually in Harbor City, rather than in Los Angeles, because of the influence of the longshoremen. Dr. Wallin was sent by Dr. Kay to start the group in the Harbor City area in San Pedro.

Huth: And had Dr. Wallin been with Dr. Kay before that?

Shragg: They were both at Fontana. And he also hired Cohn and Solomon as the other two of the first three people. And they were the genesis of the medical group down there. That was before the Los Angeles area actually opened up.

Who else? There were a number of others, I'm sure. I'm sure I've skipped over many of them, but those were some of the people.

Huth: What was it like when you first went there?

Shragg: Well, when I first went there--I can remember the first day I arrived—I walked in there, and Dr. Cohn, whom I'd never met before, was generous, friendly, and immediately invited me over for dinner that night to meet his family. It was just a very close-knit, caring group of people that just impressed the hell out of me.

Huth: Were there other surgeons there?

Yes, there were three other surgeons. Besides Dr. Eastman, who was the chief, and Dr. Solomon, who was a surgeon, the fourth one was Dr. Patrick Eugene Yoklavich--we called him Pat. And he and I also became very, very close. We really worked so closely together, it was just a very comfortable relationship. There was just no question of helping each other, caring for each other, backing each other up. It was just a very comfortable, professional relationship, except for the problem with Dr. Peter Eastman, and these other things that came up--which were significant--the rest of it was a very high-level, professional relationship.

Huth: How was it for your wife, when you went to Harbor?

Shragg: She liked it. She was fond of the wives of these people that we were close to, and she was very content, very happy--particularly with the idea that we could call some of the hours our own. She was very, very pleased with it.

Huth: And with the schools?

Shragg: Well, the schools were in Westchester, and as far as we knew, the public schools there were fine. There were never any reservations from her about other wives of other doctors in private practice. She was never jealous, or envious, or even concerned.

Huth: None of those problems.

Shragg: None of those problems about--well, you know, "You're making less money than other comparable surgeons." That just never ever arose, which was rather fortunate. Not that we didn't want the same material things that others did. It was just a quality of life that pleased us both.

Huth: When you came here, were you aware of the reasons that other doctors were with Kaiser and not in fee-for-service practice? Was there any indication, or did you talk about such things?

Shragg: Oh, sure. Those that I spoke to had the same basic motivation that I did--philosophical, social. I have very close friends of mine in private practice, and when I talked to them about it they had some reservations, but one of them in particular, Jerry Nudell, who's been fee-for-service as an anesthesiologist, touted me onto a Dr. Clifford Portnoff, who was a surgeon up at Los Angeles, who had been with Permanente earlier than I in the early '50s. And he left for private practice--he and Dr. John Winkley just, somehow, didn't get along, or maybe he had some conflict with Dr. Kay--I'm not exactly sure.

I met with him, with Jerry Nudell. My cousin suggested that I meet with an ex-Permanente physician-surgeon, and I did. And he was very positive about the concept, the philosophy, the idea. It was just the personality thing that made him leave the group. He reinforced the idea that, if I was going to be in Harbor City, that I might be okay there. He had obviously had some conflict with Los Angeles. So he was, in a sense, even supportive there. Some of our best friends in private practice are physicians who have left us for a variety of reasons, because not everybody is for group practice, and group practice isn't for everybody. So that was a reinforcement of my idea of joining the group.

Personal Growth as Surgeon and Medical Administrator

Huth: How were you doing as a surgeon?

Shragg: I was just great; I was just doing terrific. I had so much work, and I was doing things that I was trained for. I was given exciting and interesting professional things to deal with--much more so than physicians of my same age in private practice. I know that because of some of the fascinating cases that I took care of in those years. And even now I'm aware that as a young surgeon just out of training, I'm sure, in Minneapolis patients would have gone to some older, senior people. And here I had an opportunity to gain that exposure and experience.

I tell all the doctors that I meet with now--and especially those involved with surgical, procedural things--that with our group they will do more, and become better in their particular discipline, than if they were in fee-for-service, solo practice. And that's just because of the amount of interesting pathology--which is, after all, the main thing that we're in this thing for--in medicine.

Huth: You took the American Board of Surgery examination after you joined the Permanente Medical Group, is that right?

Shragg: Yes.

Huth: What was the significance of taking the examination and being certified by the American Board of Surgery? Did it make any difference in your practicing? Did it open any further doors later on? Was it important to do that, and did most surgeons do it?

Shragg: Yes, I would say 100 percent of the people who go through a training program want to be certified or pass the examinations of their respective specialty. It is a certification that you've completed your training and have passed at least certain kinds of examinations. I know of doctors in whom I have all the confidence in the world, that are as good as I can envision, that have not passed the boards because sometimes they're difficult to pass.

Yes, I think that it's important to at least try, and fortunately I've passed them. I think that I had to be certified—that was one of the criteria that Wallin had--in order to be chief of the department I should be certified in that specialty. It would not have compromised my remaining in the group under any circumstance, and I think, subsequently, being certified has been helpful in terms of my written curriculum vitae.

I did not join the American College of Surgeons. That to me was a lesser organization. You could join the American College at that time, in those years, without being certified. To me the board certification was the more important of the two. Others pursued the paper work and so forth to get into the American College, which I never did. I never attempted to--I guess I was too lazy. I was not really a joiner.

Huth: Did it matter?

Shragg: Not for me personally it didn't. To some people it does. I'm not a joiner by nature, necessarily.

Huth: Were you a general surgeon when you first went to Harbor in 1957, and then two years later, chief of surgery? Then, were you chief of surgery for one year before you became medical director?

Shragg: No. I was chief of surgery, I think until 1964--certainly no later than '65--because that's when I became the acting associate medical director. That's when Dr. Kay appointed me in anticipation of Dr. Wallin moving over to the new Bellflower hospital to start that program. I was chief from '59 until '65. I became acting medical director in '64 in anticipation of Dr. Wallin leaving. Then when I became medical director I appointed Dr. Yoklavich as chief of surgery at Harbor City to replace me.

Huth: So he took over then?

Shragg: Right. I guess I must tell you that there was one thing that stands out in my mind in terms of the merits of our kind of practice--and as for me, I've had a lot of satisfying experiences--but there's just one little incident that stands out in my mind, and I still dwell on it: I was on call in the hospital one evening, and a black girl from Compton--which is a lower socio-economic level area--came into the emergency room with abdominal pain. I think she was sixteen years old. And she was seen by a board certified pediatrician, examined by a board certified gynecologist, and examined by me, a board certified surgeon. We took her to the operating room--she had appendicitis--and we operated on her. And the whole sequence of that one episode, to my mind, crystalized the merits, and the value, and the philosophy of this kind of practice, where the issue of whether one could afford it or not never arose. They obviously prepaid it, so they really paid for it, but it was not an issue with the hospital or me, or any of the other doctors or nurses. She was just a sick person who came in and needed help, and we just gave her what I thought was outstanding quality care. It really, to me, just kind of crystalized exactly what I thought and anticipated this thing to be. That was, to me, a very dramatic and very memorable occurrence, and I think that's what it is--that's what it's all about.

Huth: Did you stay at Harbor as medical director for about ten years?

Shragg: No. Until 1968 or '69, at which time I then transferred and started staffing for the West Los Angeles area, which was in the process of planning and development.

Physician for Planning to Associate Medical Director, 1968 to Date

Huth: What can you tell me about the medical care program when you went into West Los Angeles?

Shragg: The Kaiser Health Plan purchased a nursing home in Inglewood on Manchester Boulevard, and we modified the nursing home into an acute care hospital with the addition of some operating rooms, an x-ray department, and an emergency room, and the modification of some nursing units.

In the development of the West Los Angeles area, we incorporated what was previously an outlying clinic at Inglewood that was headed by Dr. Irving Rasgon, who was the physician in charge of that clinic. The words "physician in charge", are also abbreviated to PIC--it's a different terminology than the one in northern California. Dr. Rasgon is now chief of family practice at Los Angeles, and assistant to the medical director there.

The West Los Angeles Complex of Clinics: Inglewood, West Los Angeles, and La Cienega

Shragg: There was a grouping of several outlying clinics that were affiliated with the Sunset, or Los Angeles area--as distinct from the Harbor area, as distinct from Bellflower, Panorama City, Fontana and so forth. So there was the outlying clinic in Inglewood; West Los Angeles, which was at Sawtelle and Olympic Boulevards--most of them made up of general practitioners, pediatricians, and some internists--the La Cienega Clinic, which was at La Cienega Boulevard and Beverly Boulevard--those three clinics; and the beginning of the hospital at Manchester--that is, the renovated nursing home that was the beginning of the West Los Angeles complex.

So the staffs of those three clinics, plus those that we added to Inglewood, constituted the West Los Angeles area. And some of the doctors then were hospitalizing their patients at Inglewood, rather than at Sunset and so forth. We began with, in addition to those clinics, several surgeons who were at Los Angeles: Dr. Robert [Bob] Herzberg, Dr. Robert Jackson, Dr. Herman Wirka, and Dr. Gregorio Ching. In medicine there was Dr. Stanley Zemer, who was the first chief of medicine, who came from Sunset; Dr. Bledsoe, who I mentioned earlier, as chief of radiology; Dr. Winston Jesseman, who joined us at Inglewood as a thoracic surgeon, and Dr. Frank Fletcher became the first chief of family practice. He was at the Inglewood Clinic. And there were a lot of other doctors, but those were some of them. Some internists who were at the La Cienega Clinic included: Drs. Ira Levy, Jerry Drexeler, Manny Warson, and Al Glick. There was a Family Practice Department, as distinct from internal medicine.

Huth: I'm not sure what that is--family practice.

Shragg: It's a primary care doctor--like a general internist used to be--medically oriented.

Huth: Both children and adults? Is that why it is called family practice?

Shragg: They take care of whole families, theoretically.

And Dr. Minoru Yoshida was the first chief in pediatrics. He transferred from Sunset also, and he is now at our Anaheim facility.

Huth: That's quite a list of people.

Staffing the New West Los Angeles Medical Center on La Cienega Boulevard

Shragg: So that was the genesis while we were building the West LA facility, and we moved into the West Los Angeles Medical Center on La Cienega in August 1974. We started planning it in 1968. Dr. Sharzer, whom I mentioned earlier, subsequently transfered from Harbor City to become chief of Ob-Gyn when we started that service, and he currently is also an assistant to the associate medical director for West Los Angelea.

Huth: Were you responsible for naming these people as chiefs? Did you have that role?

Shragg: Yes. I was helped by Dr. Kay, and Dr. Herman Weiner, and Dr. Maurice Yettra. Dr. Yettra was chief of medicine at Sunset at the time, and Dr. Stanley Zemer was part of his department, and he recommended Dr. Zemer to me to become chief. I knew Stan from being on the board of directors with him, and that was a good choice.

Distant Relationship with the Los Angeles Regional Center and Flawed Patient Choice of Care Location

Shragg: The interesting thing in these relationships was that the thrust as we began these major services, at least the naming of chiefs, primarily from our Sunset facility--that is, Dr. Jackson in surgery, Dr. Zemer in medicine, Dr. Yoshida in pediatrics--was done mainly because the Inglewood, or West LA facility was hopefully, to help relieve the bed pressure and office pressure for the Los Angeles area. The idea was--as Dr. Weiner, Kay, and Yettra convinced me at the time--that the heads of these departments, all being Sunset [Los Angeles Medical Center] doctors, meant that their liaison or relationship with Sunset would be a very close one.

That couldn't have been further from the truth because, as soon as they left, and we had some problem with patient transfer from one area to another, they at Sunset said, "It's your problem, take care of it. This brotherhood business only goes so far." Beyond that, you know, it was almost as if we weren't even one group, much less having a close relationship.

That same experience was noted when Bellflower left Harbor City--that is, when Dr. Wallin left with a lot of Harbor City doctors. And then patients went to either place, and doctors said, "Why don't you go there? You live closer." It was just crazy, just nuts, that these things had to happen. Instead of worrying, they should accept the fact that the patients really have the choice to

go anyplace they want to.

The same phenomenon occurred when Anaheim started out with a lot of doctors from Bellflower. There was the forming of a nucleus of a new area adjacent to the Bellflower area, and the hostility between those two staffs, and patients being caught between. That was another similar experience.

Huth: Is Anaheim one of the later ones?

Shragg: Yes. See, first there was Fontana, then there was Harbor City, then there was Los Angeles. In 1962 Panorama City came on-stream; in 1965 Bellflower came on-stream--in 1965 San Diego also joined. Then after that Anaheim, I think--I'm not exactly sure--was in the '70s. And the Woodland Hills facility just opened up a month ago as the ninth medical center in that area. The same thing occurred when Woodland Hills, our newest medical center, split off from Panorama City.

So that wonderful feeling--that the liaison at Sunset would be enhanced by having them--they were good people--but that part just never materialized.

Huth: So did it mean that you were meant to shift for yourselves?

Shragg: Well, whenever you called--it depended on who you knew. For example, in some of the sub-specialties, if I called Dr. Leonard Buck, who was chief of ENT [Ear, Nose, and Throat] there, or the ophthalmologist because we didn't have the specialties in our clinic--that was not a problem. They were very nice, and helpful, and to this day that relationship is fine. But in medicine, and surgery, whew--terrible. And in Ob-Gyn, when we did not have an Ob-Gyn department in existence, whenever we needed some consultation the resistance was just appalling.

Huth: Can you point to a reason?

Shragg: Yes, everybody was busy and hardworking, and some people just aren't willing to help their colleagues, when, in fact, you need their help. I could never understand that. It was my philosophy, and I would hope that, if somebody calls you for help, they are not just calling for fun; a patient is in need, and if you can provide it--isn't it wonderful? If you can't provide it, then that's different. But it was always with resentment--we still have that in some departments, as to our patients going from one place to another and coming back—in psychiatry, for example. One of our partners at Sunset simply refused to see a patient because that patient ostensibly lived in the West Los Angeles area.

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Shragg: A health plan member has the prerogative to seek care anywhere they choose, and it's really not our business where they choose to go. It's our business to take care of them. We obviously prefer that

they stay closer to home, but somebody may be working in one area closer to one hospital and living in another area. That's one of the very merits of our program, that we are diversified and widespread enough that a patient does have that. It is not the system, it's the individual. Because, if you call up a particular doctor, they are just always helpful, and grateful, and gracious about it--and others just aren't. Again, that's the personality thing in a very large organization--it's depersonalized.

Huth: Don't you think sometimes it's the staff under the doctor that does that, or is it always the doctor who does it?

Shragg: No, it's always the doctor. The doctor can't cop out on his nurse anymore, in my judgment. And if the nurse does it, then it's the doctor's fault because it's his/her responsibility to see that the aid acts on his/her behalf. It's one thing to say that they're tired and busy, and to try to make it more convenient; that's okay, that's understandable. But some of them have a resistance. Now, I'm generalizing on some existing problems--I must tell you that the vast majority of the time things work very nicely. But we still get that cropping up.

At the beginning it was more difficult, but as we become more independent and have more specialties, and we are able to provide for all of the care that the medical center can, that conflict arises only when a patient happens to be either unhappy with us, and goes there, or vice versa. And then the doctors there may attempt to reprimand the patient. It's not the patient's fault.

Huth: Do you think some of your members leave because of this?

Shragg: It's hard to say. I'm sure there's some unhappiness because they may come here and say, "How come we get better service here than at Sunset," and vice versa.

Huth: They have the dual choice, so can't they then decide to leave Kaiser Permanente and join another helath plan?

Shragg: Well, they can--the dual choice is an option. They may get more personalized care on the outside, but a lot of them just--I don't know if they leave for that reason. I don't think that's the major reason. It's just an internal thing that really ought not to exist. That's all.

Huth: Is there some way to solve that?

Shragg: Yes, you've got to knock heads. [laughs] If it's a problem that we have here, then we ought to solve it, but not take it out on the patient. The patient is the unfortunate person who's caught in the middle. We have the problem of doctors getting upset with the patient instead of taking care of the problem, even if the patient

is wrong. They should take care of the patient's problem, and then try to resolve the problem with the patient. But when they try to resolve the problem with the patient before they actually treat them, the resentment and the hostility between the patient, the doctor, and the system is just compounded.

Huth: Do you think there are some patients who are sophisticated enough to work around this and stay at it long enough so they can get what they eventually want? That there are others, who get lost by the wayside because they don't know what to do or how to maneuver?

Shragg: Exactly. I think you really hit the nail on the head with what I think is the most difficult problem we have in the program, and that is that patients who know how to use the system to their advantage are our happiest patients, and our most content, and they get the best care. Those who don't are the most frustrated. There are ways of using the system, and it's our responsibility--and we obviously have failed with a very significant number of our members--in the matter of having to teach them because we want them to use the system more appropriately.

In that respect we do have some blockage by our receptionists, and nurses, and contact people. There's no question about it. So when I get a patient who's frustrated, I tell them to call their doctors--assuming they have one--and insist that the nurse have the doctor call them, and not just let the nurse say, "Well, he's busy," and have the patient call back. Because, I think, once the patient has made the attempt, it is our responsibility as an organization to follow up on it.

I had a Permanente doctor once--who was very busy, no question about it, but a little reluctant at times, or frustrated, perhaps--who had one of his old-time patients write me a letter complaining about how wonderful the doctor was, and how busy the doctor was, and how frustrated they were in trying to reach him, and putting all the blame on the receptionist and the acute care nurses. In my judgment, there's no question that the doctor manipulated the patient into writing this letter--and with some good intentions.

So I wrote the patient a letter, and expressed my condolences for his frustration, and I gave him the doctor's personal telephone number as well as his home telephone number, and said, "I'm sure if the doctor's so wonderful, as expressed in the letter, that he would be more than willing and generous to talk to you on his personal phone line." And that doctor stopped having patients send me letters from that point on.

Huth: Clever solution.

Shragg: Well, I tell patients to insist when they talk to the nurse that they want that doctor to get a message, and the doctor has to answer it, of course. But sometimes nurses and receptionists can frustrate the patient. You know, it's not all black and white. Sometimes patients do bother them, but that's their prerogative, unfortunately. We have to be responsive to them.

I must emphasize, however, that what we have just discussed is a problem with a minority of patients and only a small number of physicians. It was simply to emphasize that it is one of my major frustrations that we as a program have to deal with and to address. The vast majority of patients and staff are satisfied, or we would not still be in business.

III HARBOR CITY HOSPITAL'S UNIQUE COMMUNITY CARE PROGRAM, 1967-1969

Huth: Can you tell me something about the poverty program that you worked with--the one hundred families? I'd like to hear whether there was resistance to the use of the funds for this poverty program? Was there any anxiety by physicians about going into it, or from the patients and the regular members about having it?

Shragg: Well, the answer to all of the above is, yes. Yes and no. The social program was something that I was always fascinated with and interested in. We really had such a terrific organization and medium to provide care to a whole variety of people that otherwise could not afford it. And that was during the height of President Lyndon Johnson's Great Society programs. Everybody was working under OEO [Office of Economic Opportunity] and Headstart Programs and all sorts of other attempts at bringing the poverty people into the mainstream of medicine. And I was fascinated, and interested, and motivated along those lines.

Dr. Kay and I, in our recruiting trips back East sought out some of these programs: the Columbia Point Project, if I'm not mistaken, in Boston; and other kinds of government-sponsored attempts at improving and increasing the level of care to those who were economically disadvantaged. And of course, at least in our climate, in our urban area, it involved mostly blacks, so they were doubly deprived in that respect--having the racial problem as well as the economic problem.

Anyhow, an opportunity--I forget exactly how this opportunity came--there was an OEO program.

Huth: Community funds of some kind?

Shragg: Well, we had gotten that, but there was an OEO program in the Harbor City area that involved a pilot program--what we called a parent-child center.

Huth: So this was while you were still at Harbor.

Shragg: I was still at Harbor. That's correct. And that was with Mr. Edward Bunting, who was my medical group administrator there, and Dr. Jay Belsky, who was chief of medicine. An opportunity presented itself through this parent-child center, an OEO project in which they had a hundred families that were to be funded through this federal grant, to try to provide various types of social services. And I can't elaborate upon all of them.

I forget exactly how I got involved in that, but nevertheless I did get involved, and I met with the people there. And part of their thing was to get some community support that would enhance their grant application. Among other things, part of it was and could have been the community providing medical and dental care. We had a unique situation there where we had prepaid group medicine available, literally across the street--across Pacific Coast Highway-- where these people lived. Then down the street was the Harbor City Dental Group that was, at that time, headed by a Dr. Max Schoen, who was a dentist very involved in prepaid dental practice, and is now a professor of dentistry at UCLA.

They also, as a dental group, were the first group that was also involved in prepaid dentistry.

Huth: But they had no connection with the Kaiser Permanente?

Shragg: No, just that we were philosophically obviously very closely aligned in providing medical and dental care. And so Dr. Schoen in his group, and I in our group, got very actively involved with seeing if we could provide prepaid medical care. There was always an outreach program for all sorts of OEO health programs, where they would want to get transportation, and get patients into the clinics, and all those kinds of things. That presented no problem to us because they were literally across the street. So access was not an issue.

My thrust was that here was an opportunity, I thought, to get them into the mainstream of medicine without identifying them or labeling them as poor, on welfare, or deprived, or all of the other negative connotations. It was our goal to simply get them a Kaiser Health Plan card which would be no different from mine or a longshoreman's. So that when they would come in to get care, that ideally we could not differentiate them as different from say--employed groups.

Now, that was our lofty ideal and goal. I think we achieved it to a great extent, at least. We encountered several problems. One was, as I discussed this with our group, there was a lot of resistance to this. There was the fear, which I think was unfounded, that there would be a large increase in misutilization of medical services by poor people. And there was some significant anxiety on the part of a lot of people about taking care of these

"kinds" of people, and as to why they should have different treatment than other kinds of people. I don't know, other than that--they probably needed us more than employed people needed us.

So we presented this program and the possibilities to our people.

Huth: Who would that be?

Shragg: Dr. Kay; Jim [James] Vohs; Art Weissman, our medical economist; and a lot of other people. We presented it as a project for the use of community service money to fund this thing, with the intent that, if it was successful, we could then perhaps convince the state--since this was for welfare people--to somehow continue the funding of it on a prepaid basis through either MediCal or other kinds of funding.* So it really would become self-sufficient and an entity unto its own.

As far as I'm concerned it proved to be successful. There was a lot of resistance--well, I shouldn't say "resistance" in a bad sense. There was a lot of questioning by, again, Weissman, and Ray Kay, and even Jim Vohs, I believe, as to whether anything like that could work. But anyhow they were generous enough to fund it through our community service program, and as far as I'm concerned, it worked.

These people behaved differently than others, in the sense that they didn't understand how to cope with appointment systems because their past experience had always been--going to a general hospital and simply waiting for hours and days in an undisciplined manner. If you hurt, you go and you wait, and wait, and wait, until a doctor or nurse sees you.

So our biggest problem, or one of the major problems, was to try on an on-going basis to educate them that they were as entitled as anybody else in the system--to try to remove the inferiority complex that accompanies people on welfare, and to try to let them meld into the population and the community around them, so they wouldn't be considered unique or different.

Now, some doctors and some receptionists soon found out that the letter designation "G"--in contrast to my letter designation on my medical record, a "K," or for longshoremen, a "D"--they recognized that the letter "G" somehow distinguished them from other people. So as much as we tried to give them the same identification

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*Kay interview, Regional Oral History Office

card and so forth, some people were able to identify them. But I think after a while even that blurred, so that they didn't distinguish the one from the other.

And I think the experiment worked. I think they subsequently, after I left, cancelled it. But I think they cancelled it because of the difficulties of working with the state. I think that was our first MediCal group. There was, at the same time, another OEO project out in Fontana that was funded by OEO directly, in terms of providing medical care. But at Harbor City, we really gave our efforts, not as part of the national OEO program, but just a community response to an otherwise basic parent-child center community program funded by Kaiser Permanente. It was our first effort in trying to integrate the "poor" into the mainstream of medicine.

We researched it. We studied this group of families--which, incidentally, represented a cross-section: a third were black; a third were Mexican American, or hispanic origin; and a third were Samoans--there was a big enclave of Samoans there. So it was an integrated group of cross-cultured people.

Huth: Did you do some selections, so you got one third, one third, one third?

Shragg: No. They did it--the community did it. That was part of the OEO project, so it wasn't all black, or all hispanic, or all whatever--they wanted a cross-section. And we studied them in terms of their behavior, and we wrote an article--Dr. Kovner, myself, Mr. Bunting. I'll give you a copy of that.

Huth: Who is Dr. Kovner?

Shragg: Dr. Joel Kovner is a medical economist, who was at that time working with us. He became a vice president of the Kaiser Foundation Health Plan, and has since left the organization. He's not a physician, he's a PhD--medical economist.

Huth: So he was a researcher.

Shragg: Right, so he helped us with the statistical analysis and so forth. As far as we were concerned, there were some problems. One was trying to educate them into an appointment-type, elective system, as distinct from the purely county hospital mode of practice. Compliance with medication, since medication didn't cost them anything, might have been a problem. But mainly education--to recognize that if they had an appointment at two o'clock, we expected them to be there on time, and so on and so forth.

And our problems then, afterwards, was mainly in terms of the whole problem with MediCal--and I think this was the beginning of our getting involved more. And I think we aren't involved enough in providing care for the poor--but it's an economic problem unfortunately.

Huth: Not enough money?

Shragg: Yes, the state, you know, kind of underplays it. But the problems then were less with money than they were with the bureaucracy of the state. What we wanted was to treat these people like any other group of people, no different--no more, no less than, say, a group of schoolteachers who were also members of the Kaiser Permanente Health Plan. And the damn state just wasn't about to let us do that. They insisted on us doing certain things, to which we just said, "Hell, no." Like they wanted us to give them chiropractic, and podiatry--routine podiatric services. And we do give foot care, but we don't trim toenails or corns routinely, and that was part of the Medi-Cal benefits. We didn't want to make these people unique or different, because our whole motive, eventually, was to try to integrate them into the mainstream of medicine, and not look at them as distinctly different.

We keep being examined by the Medi-Cal people in the state, and at one ridiculous examination a couple of years ago they insisted that all Medi-Cal people, who represent a very tiny fraction of our health plan, be given tuberculosis tests. We are very much in favor of that, but we obviously can't provide the tests if, in fact, they don't present themselves to our group, or to our clinics, or to our offices. Somehow they really insisted that we almost go out and literally grab them off the street and force them in to get their laboratory tests. [laughs]

And we said, "We treat them like anybody else. We advise them to do it; we encourage them to do it, but if they don't want to do it it's still America. They have a right not to get the Mantoux test, or Tyne test, and we don't want to identify this small group of people as unique, or different, and give them a service specific to them." And I think, personally, that's the way to go. So that's sort of the heart of it. I'll give you the article.

Huth: That's a very good, detailed description of that. I appreciate that.

Shragg: Well, I think it's one of the things that I'm probably as proud of as anything else that has occurred to me in my experience here. Because I'm sure we can do it better than anyone else.

Huth: How long a time period did that cover? Several years?

Shragg: Oh, yes, a few years.

Huth: And it stopped, why?

Shragg: Well, after I left--I don't know what stopped it. We still take Medi-Cal patients, but I don't know if we take them (the parent-child center population) as a group, or whether they're part of the total Medi-Cal enrollment--rather than isolating the parent-child center as a specific group of individuals. I don't know what the outcome has been. But you know, they sent me a certificate for service over a number of years. When they would have an anniversary party or celebration, I would be invited, and I went down a few times. I'm proud of that.

The dental group involvement was just tremendous. There was probably a greater benefit from the dental group's side than there was from the medical because there they could get all these kids in and really take care of their teeth. You know, that's something you can see--"before," and "after".

Huth: There must have been much backlog too, of uncared for people.

Shragg: Exactly, there was. And the dentists there, of this particular group--in fact, I still go to them as a patient--are just terrific people, and they were enthusiastic about being involved in this community effort as well.

Huth: That's interesting that you still go there for your dental care.

Shragg: Yes, Dr. Jerome Simon, DDS, is my dentist. I've just been going there for twenty-nine years. I started with them because it was convenient, and I still go there. And Dr. Max Schoen, was, again, sociologically and philosophically oriented to providing care for deprived people in that manner. And he was also oriented to prepaid group dental practice, which was rather unique in those days--always very much akin to our kind of philosophy. He was one of the leaders of that group--he has since left to go into academic dentistry, and, again, is at UCLA.

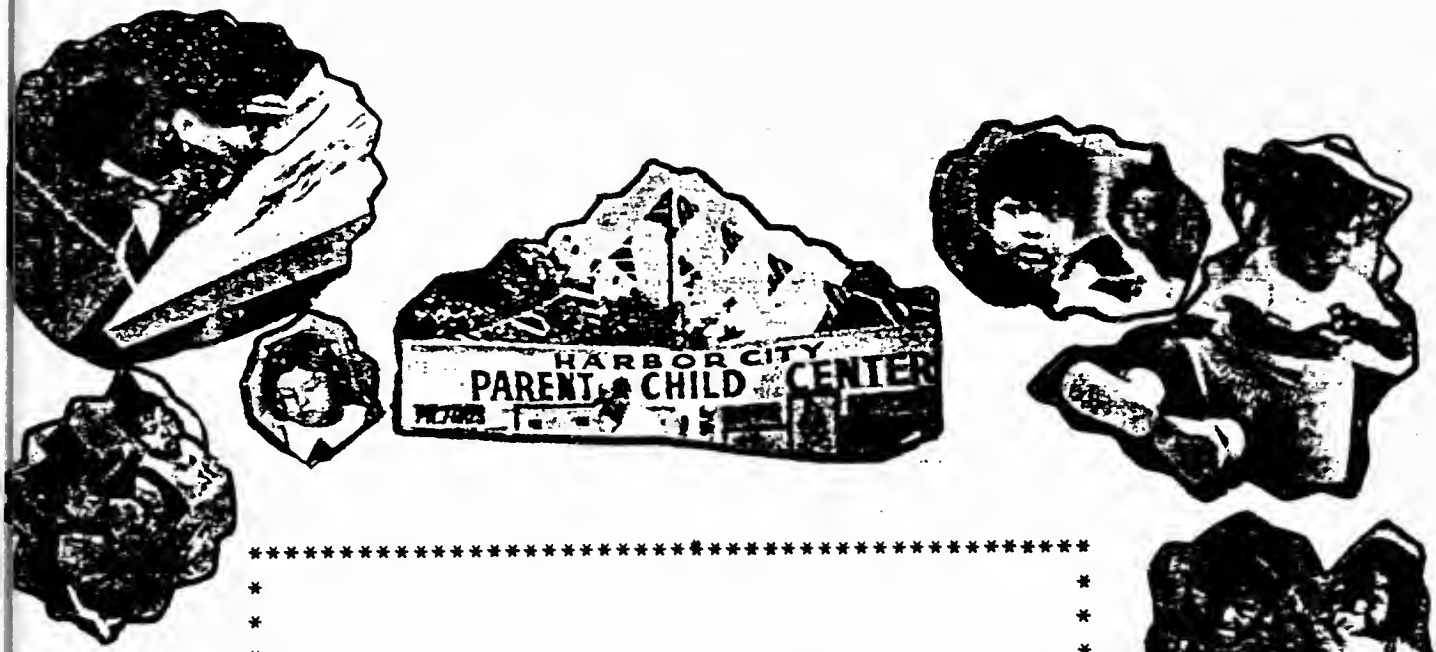
I have a lot more documentation about the Harbor City parent-child center program, if you're interested.

Huth: If you have something you'd like to put into the appendix that would be a good summary of it, we would like that.

Shragg: Well, I'll give you that certificate that they sent me, that I have.

Huth: That would be excellent. I'd like to have that.

Shragg: We got a lot of help from Jay Christie, who is the membership service director for the health plan at Harbor City. She was very involved with getting them to learn how to use the health plan.



THIS CERTIFICATE IS AWARDED TO

Dr. Harry Shragg

IN GRATEFUL APPRECIATION FOR
OUTSTANDING VOLUNTEER SERVICE
TO HARBOR CITY PARENT CHILD CENTER
THE PAST YEAR. 1968----1972
DATE

Helen L. Phillips
VOLUNTEER COORDINATOR.

Val J. Hall
PROJECT DIRECTOR.

HEW- OCD FUNDED THROUGH EYOA.

Delegate Agency: VOLUNTEERS OF AMERICA

Huth: Is she still there?

Shragg: Yes, at Harbor City.

Huth: Do you know what years that covered?

Shragg: This is dated 1968-72. Those are years when they sent me this kind of certificate. So it was 1967 and '68, because I left there in '69.

Failed Attempt to Include the Venice Free Clinic, Los Angeles County, and UCLA

Huth: Now, do you have something else to tell me about the parent-child program?

Shragg: Yes. As a result of that experience with the parent-child center program, and what, at least, I thought of certainly as an initial success--until our dealings with the state made it difficult--I got involved and did a little volunteer work with the free clinic in Venice, California. My wife and I did a little volunteer work, donating our services. We'd been touted on to this by one of our physicians who was also working for it.

Huth: Do you know what year that was?

Shragg: It had to be about 1972 because I was still at Inglewood. It was before the medical center opened up.

The development of the Free Clinic Movement, and so forth, was also intriguing and yet another attempt to provide care for medically deprived people and so forth. But they, the clinic, were really always living from hand to mouth, needing donations, and money, and resources, which were really not forthcoming. So, anyhow, we volunteered a little bit, and the idea occurred that here was something that was worthwhile because people needing care didn't have it. And I saw how inferior the basic level of care was just because of the lack of resources available. There was some funding from the county, some minor support. The professional part, from a physician's standpoint, was all volunteer work, which made it haphazard, and it lacked some degree of continuity.

The thought occurred to me that there was perhaps some way to combine the knowledge and some resources of our program, of Kaiser Permanente--and also perhaps of UCLA because there was some interest on the part of UCLA to get out more into the community.

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Shragg: Anyhow, the thought occurred that if we could provide the type of clinic--a better basis or foundation--that obviously a better job could be done. We hoped we could in some way learn from our experience in the parent-child center. But Kaiser Permanente didn't have the resources to fund the total thing because the community was not as structured as it was at Harbor City, where we could have literally a hundred families that we could plan for in a better way. By putting together our knowledge, our expertise in the delivery of care--plus, as a resource, for UCLA to become involved and provide an opportunity for their students or residents to rotate through it and provide some degree of support professionally and a learning experience, and somehow to have the county fund it because they were going to fund it anyhow--these people could be seen, or referred to the county hospital, called Harbor General, or the big county hospital [Los Angeles County General Hospital] downtown.

Then, UCLA was looking for patients to put into beds anyhow. If they were sick enough, and they needed in-patient care, then UCLA would be the place to hospitalize them. Since the proximity of UCLA to our program here at West LA [Los Angeles] was such that people in need for these services in Venice would then stay within the neighborhood, so to speak, or it would certainly make it more convenient than traveling an excessive distance to the big county hospital--that it might be worth the effort to try to combine the three different entities: our program, the county program, and UCLA's.

Dr. Baker, who was then medical director, and Mr. Dan Wagster, who was then the Kaiser Health Plan regional manager, were very supportive of the idea. And we met with people from UCLA--a Mr. Baldwin Lamson was then the UCLA hospital administrator, and there were several other representatives from UCLA. And we met with several from the county--I don't remember all their names, although I have the names of those men available, if you want that.

Huth: By "we," whom do you mean?

Shragg: Myself, Dan Wagster, and T. Hart Baker. Anyway, it was really more of a planning thing, just to get us together to see if we could come up with something. We put together a program. There were some staff people from the county who were planners that helped us, and we developed some demographics and so forth.

The county seemed somewhat enthusiastic about it, and certainly UCLA was, and the plan was that we would then provide the major ambulatory care for that Venice Free Clinic and really put it on some solid foundation. We put together a grant proposal, and actually got some funding from the Kaiser Family Foundation to support the study of it. But it never materialized, you know. We had several meetings, we were enthusiastic, it looked like it was a

possible go, then the basic underpinning of it, namely finances--for which we were counting on the participation of the county--fell apart. Obviously they had their financial problems, as everybody else did.

Part of the reason for not funding it, I'm led to believe, if I can read between the lines, is that the contracting to a private practice provider, which seemed to be somewhat popular about that time (at least the idea of maybe delegating out of some of the responsibility for providing medical care to the indigent), might be done using the private practice community--and this certainly would be one way of doing it--seemed to have fallen on some politically tough times. There was some feeling, in my judgment, at least--my interpretation--that if the LA County Medical Society, and other kinds of organized medicine learned that the county was contracting with Kaiser Permanente on the one hand to provide some care for the indigent, that there might be some difficulties. I'll never know, of course, but that seemed to be one of the reasons, and probably the main reason was that maybe the county found a difficulty in capitating a membership in that Venice area that really didn't lend itself to quantification.

Anyhow, that was an idea, that it certainly would have been nice to try to see if we could provide some kind of care--because it's just a shame that our kind of program, with some kind of government aid or subsidy funding, and even with an academic center--combining our resources and respective expertise--can't come up with a better way of providing care for the indigent. That was the Venice project, but, again, it just never got off. We never really could implement it because the county ultimately backed out. Well, it would have been nice to try.

Huth: Was USC ever involved in that?

Shragg: No, not in that.

Other Attempts at Indigent Health Care Programs

Huth: How about USC and the plastic surgery program? Was that related in any way?

Shragg: No. We had many physicians on the staff at the various academic institutions, and there are a number of residents that rotate through our various facilities as part of an on-going training program. I know that's true at UC Irvine, and I think they have orthopedic residents that rotate through. So that's not very unique.

The only thing about the plastic surgery is that when we established that with Dr. Paul Milberg as the first full-time plastic surgeon at West Los Angeles--we had plastic surgeons before, but they stayed a short time and left, so this was the first long-term, full-time department that was created—once we got four or five plastic surgeons, Dr. Thomas Krizek, a prominent plastic surgeon in America at the time, came out to USC to start a program. They had not had a plastic surgery residency program at USC prior to that. They had one at UCLA, but they had not had one at USC.

Dr. Krizek knew a couple of our plastic surgeons from his previous position at Columbia [University], and that resulted in an affiliation and an association that has been, I think, very mutually beneficial, with residents and fellows rotating through West Los Angeles. That's through the USC thing. We tried before Dr. Krizek ever came to develop a relationship with UCLA through Dr. Harvey Zarem who was head of the plastic surgery program there, but we didn't succeed in developing a relationship. It's always been hard to develop a relationship with UCLA, frankly, compared to USC. There's always been a standoffishness, or an arrogance that pervades UCLA, in contrast to USC.

Huth: Do you know why? Can you pinpoint it?

Shragg: I don't know why, but it's true of medicine, and pediatrics, and other surgery in the past, where there's been some sort of a feeling that if it's good for UCLA, it's a good program. Our feeling is that it has to be good for Kaiser Permanente as well, and if it's not then it's not a good program. In other words, it has to be mutually beneficial.

We have a tremendous amount of material in any department you can name--we've got it. We went there trying to develop an affiliation because it was to our advantage to have an affiliation, and we think to their advantage to have available resources for their training program. And we were willing to fund an extra fellow, just to be part of this thing. But USC came along, they were eager to do it, and we were eager, and it's been an excellent relationship. But that had nothing to do with any of the previous projects.

Huth: Was this in connection with the child psychiatry program for the Watts area of Los Angeles, or were those two separate things?

Shragg: The Watts program—there also it's called the parent-child center program in Watts--that was an outgrowth, also, of an effort on the part of Kaiser Permanente to become involved in the community, and it arose as a result of the Watts riots in 1965. That had nothing to do with myself or West Los Angeles, other than perhaps with my involvement in the parent-child center program at Harbor City, and

those of us who were involved with various attempts at caring for the indigents--and that would include, I think, Watts. That was more of a social program, and not necessarily a medical program, although they became members of the Kaiser Foundation Health Plan, and we provided care for them. But it wasn't an exclusive, West Los Angeles program at all.

I was involved—not directly, just peripherally--just out of interest in the whole idea of what they were doing, and how we could learn from them and see what they were doing as we got involved with our own program in Harbor City. So there was really no direct relationship with them, except for social interest on my part, and on Mr. Bunting's part. We were all learning how to try to cope with this problem of providing comprehensive, mainstream medical care for the indigent population.

IV DESIGN AND ADMINISTRATION OF THE WEST LOS ANGELES MEDICAL CENTER

Huth: What can you tell me about the move to West Los Angeles? You began in Inglewood, and you were planning the design of the West Los Angeles Clinic. What was your involvement in the design itself?

Shragg: Well, Dr. Kay asked me to think about and start developing staffing for the development of a new area in southern California, namely the West Los Angeles area, which would ultimately have its own medical center.* I had been involved to some smaller degree with some planning, as chief of surgery and as medical director as we expanded Harbor City with the guidance of Dr. Wallin, who was always involved with planning, and had some good ideas all the time. And I had developed my own thoughts about what constituted a good nursing unit, and the need for appropriate offices, exam rooms and so forth.

That, to me, was a tremendous opportunity because, first of all, it was a very good learning experience. I had fun, enjoyed it, developed some expertise and knowledge in planning, and I believe, contributed to a better plan--which obviously will never be the ultimate. So I started planning with the first architect hired by Kaiser Permanente in southern California, who was Earl Richards. He was our liaison with the architects and engineers from Kaiser Engineers, the contract outfit that was to develop the West Los Angeles facility. So I was involved since its conception, beginning planning stages and so forth.

I have an enormous collection of old memos and paperwork—I'm not sure you want all that [laughs]. But maybe I'll go through to see if there's any pertinent material.

Huth: Maybe something that helps pull some things together would be appropriate.

Shragg: Well, I can get you, at least, the names of the original planning group.

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*Kay interview, Regional Oral History Office.

Huth: Wasn't that unusual to have a doctor involved in the planning of this large new medical center?

Shragg: It wasn't so unusual, but it represented a significant departure from past practices. In the past, certainly through Bellflower development, Dr. Sidney Garfield retained control and involvement with planning of facilities. It was one of his great interests, and he certainly was very creative and innovative in many ways.

The problem was--I understand--that even though he was intimately involved with the design of facilities for the Sunset hospital, Panorama City, Harbor City, and Bellflower, and even though he was obviously the owner and founder in Fontana--which was the first medical center in southern California--that somehow in Fontana they were able to get out from under his influence years ago. But he retained his significant influence in the other medical centers that I just named.

He also did the same thing, obviously, in northern California. But perhaps because of our size--there was no way for any one man, no matter how good, to continue in these various efforts. So this represented a departure.

Huth: What year were you doing the planning?

Shragg: 1968. We started planning in 1968.

Huth: Was it 1974 that it opened?

Shragg: Right. My role was to get together various experts in the field, so that, for example, Dr. Rene Caillet--who you spoke to this morning--I asked to provide his input for physical medicine and rehabilitation--Dr. Winkley in terms of surgery, etcetera. All over the area I pulled together what were the best people in our program--who themselves would be interested in providing their expertise, based on their experience, as well as the association with the various hospitals in the program--because they were all different in terms of design.

Then I was the liaison, or coordinator, and I involved myself intimately with almost every committee or grouping, and I think I pulled together a coordinated, functional, integrated in-patient/outpatient facility.

Nurse-Patient Relationships, and the Multi-Bed Room

Huth: Was it very different from Garfield's designs? He had one plan for central nursing stations, and--

Groundbreaking ceremony for the Kaiser Foundation Hospital,
West Los Angeles, about 1970.

Left to right: Messrs. John J. Boardman, Daniel O. Wagster, James A. Vohs, Tom Bradley (councilman, City of Los Angeles, now mayor of Los Angeles), and Drs. Herman Weiner and Harry Shragg.

Shragg: All of these were evolutions--all of these designs.

At the time, in my judgment at least, the very best functional design from a patient perspective and from a nursing perspective--because the important thing in a nursing unit was the relation of the nurse to the patient, and not the doctor. Because the doctor is there a very short period of time, and the nurse and the patient are there twenty-four hours a day.

From my perspective, the very best relationship that had yet been designed within the Kaiser Permanente system was the one in southern California at Panorama City--which was the circular plan that Dr. Garfield designed. That places the nurse in as close a relationship to the patient's room as we have anyplace, with as much visibility--even though some rooms at Panorama City have three or four patients, and they are not visibly available to the nurse, that is, when the nurse walks around.

Idealistically, the best nursing unit is the old-fashioned, open ward that the indigent patient had. That's the best nursing unit because there everybody is visible to the nurse; everybody is available to the nurse; they're not hidden by walls and so forth. I did a lot of research on personal feelings, and studying, and looking at hospital designs, and it's my contention that private rooms that are hidden are not necessarily the best place to provide care for patients--that somehow patients can help each other.

So multi-bed rooms--for some patients, not all of them--are probably more desirable than everybody having a private patient room, which historically has been for the so-called very rich, and therefore, ostensibly, the most desirable place to be sick. But if you consider the evolution of the nursing unit, the very best nursing that is given is in the recovery room, which is really an open ward because they're available and accessible to the nurses, and vice versa. The nurses can't hide away from the patients, and nurses do hide from patients, and therefore aren't accessible. The intensive care unit also is an excellent place because they deliberately put the nurse and the patient close together and so forth.

And so our basic premise going into planning was that the very best unit we had available to us was the Panorama City, Sidney Garfield design, and we said, "Okay, let's see if we can make it better." That's what I think we did at West Los Angeles, and what we've emulated at San Diego, in Woodland Hills, and in Riverside. And even though it's not perfect because there are a lot of factors that have to be involved, it has really taken off from the round design. We squared it off--which makes it architecturally easier, and better, and I think, cheaper to build--we added some space. So that was our basic thrust.

Then we said that if the very best nursing care is to be given in the intensive care unit, let's design an intensive care unit, and then apply the same physical principal to the non-intensive care unit patients. Since the patients in the Kaiser hospital are really more acutely ill than say, in the community hospital, why not give them the advantage of the best possible physical layout. So our intensive care unit, for example, here, is identical to the medical-surgical unit. We just don't have the same number of nurses that we require or the monitoring equipment and so forth. But the relationship of the nurse and the nurse's station to the patient room is identical.

Now, it's interesting that those of us physicians on the committee, and the nurses, wanted there to be no barrier between the nurse and the patient, so we have a pretty open station--and it's not perfect. In San Diego, where they started out with the identical plan, the nurses somehow prevailed over the doctors, and in the intensive care unit they have put up visual barriers to the nurse so the nurses can hide behind those barriers.

Huth: Do they hide behind it? They can, but do they?

Shragg: Oh, they hide all the time. Sure. I don't know if they do in San Diego or not. Probably not in the intensive care unit. But somehow the nurses have--and we had a lot of objections; we had them here too, but we just overruled them. We said, "We're just not going to permit it." In our design of our next hospital addition, even Mrs. Long--who's a nurse, and our hospital administrator now--wanted windows in all of the various rooms, such as the cleaning rooms, the storage rooms and so forth, so that we can be sure people do not hide away from being near the patients. It's a fact of life. So that was our basic design.

The difference between West Los Angeles, now, and the Panorama City and Bellflower Sidney Garfield designs, was the fact that those hospitals have the out-patient offices beneath the hospital nursing tower, so that the offices--which have a totally different design requirement than the nursing units--were beneath the nursing units, and therefore the remodeling and so forth, was very difficult. Also the relationship of the entries of the patients to the out-patient clinic and the hospital came together.

What we did was we took the hospital tower, and we made that a separate, identified building of nursing units and defined hospital functions. And we took the out-patient part, the offices, that is, and we put them adjacent in a separate building, so that we could expand or modify the offices separate and distinct from the hospital requirements, because they are uniquely different in terms of the anticipated growth and other requirements. So if we needed to add

to a hospital, we could add that without affecting the out-patient department, and vice versa. Those are some basic differences between the West LA design and the others.

Huth: Did you study hospital design at some time or another? Was it part of your medical training?

Shragg: I just lived with it. I just knew, or I felt I knew what was needed. You know, some people would disagree with me, obviously. I was involved, I knew what I needed and what I wanted. The architects had to straighten me out on what was applicable by code—what was not permissable by code. So it was a mutual learning experience. But my thrust was, "Let's see how the patient has to respond in a certain situation, and how the doctor has to respond." The rest of it is of secondary importance.

So, for example, hospital administrators as a group would like all private rooms, and so would a lot of doctors. And here I guess I'm in a minority. They want it because it's easier to administer, even though they may seem to perceive that it's better for patient care. I've seen lots of things, lots of patients who ought not to be in a private room--they ought to be in a room with somebody else: elderly people, people with no families, people who need social intercourse, people who have to talk to somebody--because in a hospital you become socially deprived. I think that multi-bed rooms are a plus, rather than a negative. There are some disadvantages to it, to be sure.

That experience I learned as a resident when we had a very rich man patient at Minneapolis General Hospital, where I trained, who had to be hospitalized in an open ward—we had fifteen beds, I think--one of these old fashioned, open wards. He was a wealthy man, but he'd broken his neck in an auto accident. We put him there, and his wife--who was incensed that her husband had to be in this "welfare" hospital amongst all the indigents and poor people that she sort of looked down upon—wanted him transferred, but her private doctor refused to transfer him because it was too dangerous because of his broken neck.

When he finally left he had tears in his eyes, and was very upset that he was going to go to a wealthy, private hospital and into a private room. And it was he who touted me on to this thing: here he was in a room where he was trapped with his neck brace, and he was able to function intellectually and emotionally because he had people around him, and there was activity going on. He was not isolated; he was literally eight feet from the nurse in that open ward; there were people who were sick, and moaning, and groaning, and cussing, and all sorts of foul smells and odors. In other words, it was really a lively situation, and he recognized that he was going to go into a private, isolated room, and that the only people that he would see would be his doctor and nurse once a day,

and his family. That just wasn't enough, it was just not intellectually or emotionally or psychologically stimulating for him. It kept him from being bored, lying still looking at at the ceiling.

He was the one that helped me focus on this need to have other people around. There are all sorts of examples. My uncle, my cousin Bob's father, was a sick man and was hospitalized at this hospital. And he was in a two-bed room. He had a terrible heart disease, and emphysema--and the man in the bed next to him suddenly had a cardiac arrest. You know, he had no way of notifying the nurses. My uncle was terrorized, started to holler, and he got nurses in there, and they resuscitated this man. You know, there are ways that people can help each other, and I think that--

Huth: Actually saved his life.

Shragg: There's no question about it. He saved his life. We're too bound to electronic media to try to communicate, and the best way is visual communication and auditory communication. We had people who didn't want to put windows in the rooms because it was cheaper to build without a window in a room. We insisted here at West LA that there be windows in the rooms, so that nurses walking by can at least casually observe people.

So it's been sort of a hobby, and I've learned a lot, and it's been interesting--one of the rewards, I guess, that I've had.

Huth: Do you think you'll ever use it again somewhere?

Shragg: Well, I think I've used it a lot in terms of the program. Yes, I would like to use it a lot more. I would be interested in working as a consultant. Yes, I would. And a lot of people would differ with me, but they don't ask the question of what's good for the patient. It's only what's good for the administrator, or money-wise. And money's important, but in the long-term it really is patient care that is most critical.

So I think we have a very functional layout here, and--could it be better? Certainly.

Huth: Do you find out after you begin to use it?

Shragg: That's right. To take our program as is at West LA is just insanity, without stopping to say, "Can we make it better?" Because there have to be ways to make it better.

It's been fun. It's been frustrating, but rewarding, and I've enjoyed that part. It's been one of the real--I never thought of this in medical school.

Huth: [laughs] How about your time? You were doing all of your other jobs along with that; there must have been lots of overtime work.

Shragg: Well, what it did require is that I had to give up clinical practice to a greater degree than some of the other medical directors have. And that's been a loss to me, but I hope to get back into it. I guess, when I get involved in something I just go all the way, and it's hard for me. And I have a hard time delegating; that's one of my own failings.

You get frustrated with planners who have not had any experience, who come in with statistics and data. That just blows my mind. They end up acting as if they're all knowledgable, and they're just not. The advantage of having somebody like Mrs. Long, our current hospital administrator, having been a nurse, is that when we talk about patient care, she knows about it because she's been there at the bedside, and so have I. Planners have not, and they can't quite understand or comprehend the logistics, and the relationship, and the nuances.

So when I tell the nurses that I don't want any visual barriers, it's because when I used to be here at midnight or late at night I'd see nurses hiding. You know, going into little rooms where they couldn't hear the buzzer while smoking and drinking coffee. I don't have any problem with them relaxing, but they removed themselves from where they were supposed to be, which was to be close to the patient, or as near the patient as possible.

Huth: Well, thank you for going into that in some detail. That's very interesting.

Associate Medical Directorship: The Appointment Process

Huth: I'd like to hear about your work as associate medical director, and how you happened to get into that position. Was it choice? Were you elected? Were you appointed? Did it require confirmation? And what has pleased you most about being medical director? What were the good things that happened, and were there any crises along the way that caused problems? Will you please give me a general picture of the job.

Shragg: I became medical director in 1965 at Harbor City, but not by choice. I guess it was because I was there and was recommended by Dr. Wallin and by Dr. Kay. We didn't have the confirmation or affirmation process then that we have in place now. That is, now, if a medical director is appointed by the regional medical director, there is a secret ballot, and a certain majority vote has to be present in order to affirm the appointment.

I'm not exactly sure what Dr. Kay did. My sense is that he spoke to a number of people at Harbor City. Dr. Wallin recommended me, and Dr. Kay simply appointed me. The board of directors of the medical group confirmed it, but that pretty much was academic--at least in those days. It still is, but in those days it didn't require a secret vote or ballot by the partners in the area to affirm such an appointment.

It was only because Dr. Wallin accepted the responsibility of starting the Bellflower facility and medical center. So that was the beginning of it. Again, it was not anything that I sought, or somebody else would have gotten it. I know that would have made zero difference. I just replaced Dr. Wallin. The frustration at Harbor City when I first took over was that Dr. Wallin took the doctors who left with him. And the clinic administrator who left with him left by choice, not by edict, and I was left with a different corps of people--a number of good doctors. But some of the cream of the crop, so to speak, also went to Bellflower with Dr. Wallin.

So there was a rebuilding process that turned out to be necessary, in addition to having a new clinic administrator who probably was somewhat inexperienced. At first, that waa Mr. Robert Collins, who came down to Harbor from Sunset. He was an assistant to Mr. Jack Croft. He was there a relatively short time, I think, less than a year. Then he left, and Mr. Bunting came. Mr. Edward Bunting was a gem, a very dear friend of mine to this day. We worked together very well, and he stayed on at Harbor City after I went to West Los Angeles.

I was then reaffirmed and appointed officially to West Los Angeles in 1971, as a member of the board from West Los Angeles, because, from about 1968 or '69 until '71 I was somewhat in limbo. I wasn't at Harbor City, and West LA hadn't yet been defined as an autonomous medical area--although I participated in planning the administrative structure and in meetings with Dr. Kay, and subsequently with Dr. Weiner and Dr. Baker. I think it was '71 that I was appointed officially to West Los Angeles as the area's associate medical director. I was reappointed and reaffirmed by partnership vote in 1977, and then again in 1983 at West LA.

Huth: That's every five years?

Shragg: Every six years. Then my term of office will be over just by virtue of my age. I believe at the end of the year 1989 I'll officially be out of the partnership--as of January 1, 1990--because I will have become sixty-five years old.

Huth: That's mandatory?

Shragg: Correct.

Insuring Quality Care, an Excellent Staff, and Good Facilities

Huth: What were some of the good things that you remember?

Shragg: I would guess probably the best thing that happened is that I met some fabulously wonderful people that I've worked with all these years--many of them I've named. I've not named any people from the health plan or hospital, but there are also some good people there, too. But they are friends of mine, and so people probably are the most important thing.

Being involved with planning, and developing, and architecture, and seeing something grow has been a major plus in my career. And learning through some of my past mistakes and other people's mistakes--how to do things better. One of the frustrations is trying to convey that to younger people, who unfortunately are going to learn through the same mistakes. That's always tragic. That involves two things. One is facilities, because I think I've become knowledgable and expert in facilities, and the other is pushing for something that you think is right rather than giving up. Some younger people say, "Well, I can't buck the system." Sometimes you have to buck the system.

The most important thing that I think a medical director, and a chief, and anybody has, is to consider that you're here to take care of the most important person in this building, which is the patient. I think sometimes in our bureaucracy, and red tape, and frustrations, we--those of us who are farther removed from a hands-on relationship with the patient--sometimes forget that. Because it's absolutely a problem with non-MDs and non-RNs who are in administrative positions. They literally don't have any understanding or feeling about what our product is, which is really patient care. It's not that they're not good people or caring people, or that they don't want to do the right thing. They just sort of get hung up on paperwork, and all sorts of processes, without knowing or even being oriented on--and that's an organizational problem--how they fit into a direct patient care responsibility.

For example, we have a problem with our purchasing department now. We requested--in terms of batteries that we use in our beepers, which are critical to communication to people on call--the very best quality batteries, which is the Duracell battery, I'm told. Instead they gave us a cheap imitation because it was cheaper, and as a result of that, we frequently had beepers that failed to work properly on weekends, or that worked inadequately. And the net result was poor patient care.

Huth: Who decided that?

Shragg: Our bureaucracy, our purchasing department--simply because we have certain policies which say everything will go out to bid, and you don't have to take the lowest bidder, but if you don't you have to give some explanation. That's an oversimplification of it.

When we complained about it, there was no responsiveness, no concern, no understanding, no caring that we were not out to waste money--although in the long term it actually saves money because we had to throw away more bad batteries than I'm sure we would have if we had had good batteries. But the most important thing is that the patient was poorly served--we frequently couldn't contact an orthopedist. They thought that they were never called, and it turns out that their batteries failed. You can say, "You ought to check the batteries, but there's a limit." We ought to give them the best quality that money can buy, if in fact that's the only way to give good care.

There are all sorts of things. We have doctors in outside community hospitals that do emergency work for our patients that don't get paid promptly. As a result they refuse to take care of a patient that says they're a Kaiser member. That's a direct result of our inability to do what is right, which is to compensate outside people in a reasonable manner, promptly, because they're entitled to their compensation--little things like that. And yet the system is bogged down with that kind of frustration, and they do affect direct patient care to our members. Somehow we've got to get the message to them that they have to recognize that.

Huth: Is this a large number of people compared to your total staff?

Shragg: Yes, it's significant. It's people farther removed, especially in the regional offices where people never see a patient. They never see a bleeder; they never see somebody who's in pain, or somebody in a wheelchair and so on and so forth. Here, at least--some of our receptionists and doctors really couldn't care less--but at least they're here with patients. We can at least identify that. That's one of the big frustrations. That's one of the big jobs of the medical director.

Probably the most important job is to select quality people, and the most direct people making the selections are physicians and top administrative people. That, I think, is my most important responsibility--doing that with the chiefs of service. My responsibility, and that of any medical director with any experience, is to find a way to support the chief who by virtue of inexperience doesn't have the wherewithal, or the guts, to terminate somebody in a timely enough manner--who may not be up to the standards that they really want. And then not to be concerned that, if they don't keep this person on, that they're not going to get another replacement promptly, and therefore will be working short-handed. To convince them that working short-handed with good people

is better than working with enough people--one of whom may be a bad apple. That, I think, is the most important responsibility that we have, and I think we're doing basically a better job in convincing more people of that, at least at West LA. But I happen to have some very good chiefs of service, I think, and they agree with me, and they don't hesitate to be critical of people.

Huth: Once they get into the position where they have the authority, do they have to learn how to do this because it isn't part of their medical training?

Shragg: Yes, I think so. They have to experience it. And I must say that when I became a chief--and I was younger than hell, and even though I was somewhat critical of Pete Eastman as an administrator--suddenly I recognized that it wasn't all peaches and cream, and that some of the things that he was confronted with were things I was not aware of. One becomes more tolerant once you're in somebody else's shoes. They have to learn that, and it's my job—by virtue of my seniority and experience—to tell a younger doctor to enforce the concept so they do not make the same mistake that I may have made by accepting somebody into partnership years ago. And that's difficult.

Some of my colleagues and I differ on this issue. I, for example, if I know somebody is no good, if I know that—and sometimes I don't—and the chief, especially in a small department, is willing to try to go along with that person and make him a partner--I won't permit it. Some of my other medical directors say, "Well, geez, if your chief really wants it that badly, who are you to really counter that?" But I think it's because the chief thinks that they'll improve with time, and I'm very—

Huth: Do they feel that you're taking back some of their authority? Do you have that happen? Or are they happy to have some back-up help?

Shragg: I think they're happy. I think underneath it all they're happy that they can sort of say that, you know, "That jerk, Harry"; or "That bastard, Harry"; or "That hard-nosed Harry," or whatever term they have—they do that. I'm fortunate now, in that I have enough people with enough experience in some of the bigger departments--medicine, surgery and so forth--who reinforce that philosophy, of, "Don't take anybody with any significant reservations" because people won't get better. They just don't. And I'll argue with any group of psychiatrists that you want about that. I think I've got my psychiatrist even agreeing with me for a change.

So that, I think, is the most important responsibility. The other thing is to try to keep pushing for what you think you need, in terms of facilities and resources, to keep your doctors content. I believe that we probably have the most, and the best, and enough facilities--better than at any of the other medical centers in

southern California. I think I've alienated some people at the regional office, but I think they respect me that it's not because I want it for my own personal ego--I really believe that. I hope that's true, because it's not for me. If my doctors and nurses are happy, and the facilities are good, and the quality of life is better, I believe they'll give better patient care. I don't think there's any question about it.

Importance of Medical Experience to the Medical Director's Role

Huth: Did you realize when you took that job that you were giving up your surgery practice?

Shragg: No. And if you ask me why I took it, I guess I just didn't know enough, and I don't know what the future is. When I became medical director, I was practicing almost full-time as a surgeon at Harbor City.

Huth: Did you try for a while to continue that?

Shragg: Oh, for several years. I didn't really give it up at first. Even when I moved to Inglewood I still worked in the emergency department just to keep my hands wet, and to continue taking care of patients. Because it wasn't fair to be a primary surgeon and then not be able to fulfill all the responsibilities required for that. So I worked in the emergency room almost half-time because there the on-going continuity of care was not an issue. It was a matter of just taking care of people acutely, and then having somebody else continue with the care.

Yes, I miss it, and I'm looking forward to getting back into some phase of it when I'm through being medical director. In fact, I'm really anxiously looking forward to that. Would I have done it again if I had known that I'd give it up completely? Probably I wouldn't, but I guess, in retrospect, I'm glad I didn't know it--I thought I could do both. Because everybody, including Dr. Kay--Dr. Kay, I think, was practicing two or three half-days a week—and I think that's one of the strengths of our program that, administrator or not, we continue to be good doctors.*

Huth: You have the example of Dr. Kay doing it before you.

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*Kay interview, Regional Oral History Office.

Shragg: That's right. He did it. We had one doctor who didn't do it, Dr. Weiner, and that was to his downfall in terms of not continuing on with the active practiceof medicine.

Do I think it's important that a doctor be here? I think that was one of your questions. I think it's absolutely critical. There's just no way, in my judgment, that administrators--and I define them as professional administrators, in contrast to doctor or nurse administrators--I don't think they can understand the problems. In spite of their goals and desires for good patient care and quality patient care, which is never to be questioned, I don't think they know what is involved, and they don't understand the problems of the provider--the physician, the nurse, the day and night responsibilities, seven days a week.

And therefore I think it's critical that a doctor be involved, and one of the strengths of the Kaiser Permanente thing is that there's a group of physicians who work with business people, administrative people, that help on the hospital side, and even within the medical group side. That creates problems in terms of relationships, but I think when they are overcome the ultimate product is a better one, in terms of the people working within the program, and I just have to believe in terms of the care provided for the patient.

There are all sorts of examples I can give you, if you want them. [laughs] You want one example?

Huth: How about one example?

Shragg: One example. I had on-going fights and arguments with Dr. Joel Kovner that I mentioned earlier, when he was responsible for our facilities program. Joel is a very caring person and a very close friend of mine, and he and I would get into violent conflicts frequently about what I deemed to be needed for West LA, and doctors, and nurses, and patients. He would be looking at statistics.

And I remember once we had a chronic bed shortage here. But what the statisticians didn't understand was that we would be 110 percent occupied in terms of bed census on Monday through Thursday, and then about 50 percent, or something like that, on weekends. The net outcome on a monthly basis was that we had maybe an 80 to 85 percent bed occupancy, which is not a bad number. So when I'd complain to him that we needed more beds in a hurry, he would constantly refer to the fact that we were about 85 percent occupied, and therefore there must be some 15 percent beds available at all times.

I couldn't convince him, so one day--he plays racquetball every single day, like a clock—I know where he plays because I used to play with him--I called up his sports club and left word for him to call me, that it was an emergency, and that he should stop by here on his way to his regional offices, which at that time were on Sunset Boulevard. He had to go right by this hospital. He got the message, and he called. He was in a panic—he's a very emotional guy--and I said, "Joel, you just have to come here; it's critical, it's an emergency." "Well, what is it?" "I can't tell you."

He came in here that morning, and we literally had nine patients in our Emergency Department beds. We had no beds in the hospital—literally no beds. And these nine patients were all critically ill. They were either hemorrhaging or had had heart attacks. They were getting good care, but it was really a problem. I brought him in and even he as a non-doctor could see that these patients were very, very sick. And I said, "Okay, mister, find me a bed. You tell me I've got beds—you find them for me. You told me I have beds. You refused to go along with my forecasts, my needs. Now, I can't find a bed, and I need your help. You go find one."

And he almost went into tears--he really did. He recognized what I'd been trying to tell him. I had to hit him over the head with a two-by-four in that manner to get his attention.

Huth: What were they allocating then, in terms of ratio? Do you know?

Shragg: Well, you know, everything was delayed. It wasn't so much the ratio when we said we needed more beds--because we had three or four or five days a week that we were literally cancelling patients. What those people don't understand is that when you have to cancel a patient who has elective surgery--let's say your daughter had to have surgery, and we had to cancel it because it was not an emergency but because we had no beds. It's easy for them to say that, but I'm the doctor, and I have to tell your daughter, and she gets visibly upset because she probably may have called you, her mother, to come down and be with her. You had to change your program and plans in terms of where you work in order to get time off, and maybe she had children that had to be taken care of and so forth.

All of a sudden I say, "No, we're going to be operating in two weeks," and she has to make different plans at work, and at home with her family, and with you. The domino effect is just staggering in terms of the negative effect of just something simple like that. And I, the doctor, take the brunt of the hostility of that patient because Kaiser didn't do this or that, or whatever it is, or, "You couldn't take care of me, and I'm paying high rates," and so on. And I pay in terms of receiving the hostility instead of having the hostility thrust where it really belongs, which is, at that point, Dr. Kovner's office or whatever.

Those are the sorts of things that we do, and the average administrator doesn't understand that. That's the biggest problem. I'm digressing—.

Huth: No, that's not digression. That's answering my question. That's what I asked you.

Selecting and Hiring Physicians, and Advising on Other Appointments ##

Huth: Did you and do you now have any responsibility for recruiting doctors?

Shragg: Well, we now have a formalized process in place--depending on our budget availability—of what kind of doctors to look for, hire, and recruit. So the medical director is always intimately involved in his own specific area. The apportionment of resources—how many internists versus surgeons versus pediatricians--is a local option. We are involved. The chief does most of the interviewing. And when there's a question, or if there are any reservations, I don't get involved. I'd just as soon they not pursue it. But if there's someone they would be interested in, I do like to be involved in meeting the person, and for a number of reasons: One is—especially in small departments, where they've not had the experience of meeting people and interviewing and so forth—I want to be involved. In the larger departments, in medicine in particular, Drs. Oliver Goldsmith and Robert Herzberg in surgery are very good at it, and I have absolute faith in who they select and want to select. But I want to meet those people anyhow because I'd like, as much as I can, to know everybody, and to relate to everybody on a personal level if it is possible.

One of the difficulties of getting older is that, as much as I consider them as my equal colleagues—the young doctor—I know that they look at me as the old man, or the gray-haired guy, or any other kind of adjectives that they want to apply to it, and that they see me in a different generational gap, and therefore they don't treat me as equally as I want to treat them. There's a generation distinction and difference. That was hard for me to accept, also.

But yes, I am involved. I think it's critical that the medical director remain involved. Some of them don't, and I think they make a terrible mistake. We used to go recruiting, and Dr. Kay, I imagine, must have talked to you about their recruiting trips--

Huth: Yes, he did.

Shragg: So I was part of that in the earlier days, when Dr. Kay, Dr. T. Hart Baker and Dr. Fred Scharles used to be the three people that did the recruiting.* When Dr. Scharles became sick in 1965, or thereabouts, I was recruited on a last-minute basis to replace him. So I think I was the first new person added to the recruiting effort, and subsequently the whole program expanded over the years until approximately ten years ago when we abandoned the major recruiting effort. It was enormous work to do what we did, and Dr. Kay single-handedly practically did it. How he did it is unknown? The guy's just amazing, that's all.

Huth: If you abandoned the program that you had for recruiting, what did you replace it with?

Shragg: It was no longer as necessary because by that time we were well-known, and people came out from the East to apply. We made specialized recruiting efforts for certain selected specialties we had difficulty with, but by and large, it wasn't as necessary in order to fill our staffing needs as it was before that, when we were looked down upon, and we were not well-known, or well-respected perhaps. It's hard to know, but it was necessary to attract certain quality doctors and that was one way of doing it. Especially from the East Coast, to get them to come out West was difficult.

Huth: But that's no longer a problem is it because aren't there plenty of people coming to seek jobs?

Shragg: Right. Well, we have done, again, selective recruiting for orthopedics, and things like that. We do it on a selected basis when attending orthopedic and other specialties events, at national meetings and so forth. But we used to put out thousands of letters to different institutions saying, "We're coming," and try to get lists of residents and fellows, and send them all individual letters. It was a major, major effort.

Huth: It must have taken quite a bit of Dr. Kay's time and your time.

Shragg: Well, all of us. We'd be on the road for about three weeks at a time. A lot of people thought it was fun, and part of it was interesting--you know, I used to go to the Mayo Clinic, to Minneapolis, Boston, and New York. I've at times gone to Columbus, Ohio, and then to Cincinnati, Ohio. We would just beat the bushes, and go and meet as many doctors as possible. It was tough--it was like being a salesman on the road; I'd never experienced that before.

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*Kay interview, Regional Oral History Office.

But it was difficult. It wasn't the fun-and-games, eating out every night, and being away from your family. It was not all peaches and cream by any means, but it was important.

Huth: As medical director, can you tell me what was required to choose someone to be a hospital manager or health plan manager?

Shragg: I'm not involved in that. I don't have any authority—

Huth: Do you have any input at all?

Shragg: No, not on any regional manager appointment. I have been consulted in the past when the hospital administrator, namely Mr. Russ Williams, appoints somebody to be the hospital administrator in the hospitals that I've been at. I've been consulted, and I'm not positive that I necessarily have the veto power over any selection. But I am consulted, and I guess if I felt strongly about a person I could make some noises and something would happen.

Huth: Is that the medical director over all regional medical directors who does that?

Shragg: No.

Huth: Who does make that appointment?

Shragg: Remember, we are three organizations. The Southern California Permanente Medical Group is separate and distinct, and I am a partner in that medical group, and we are a partnership for profit. Then there's the Kaiser Foundation Health Plan that's a separate organization.

Huth: Each of these are completely separate?

Shragg: Correct. And Kaiser Foundation Hospitals. So Mrs. Ophelia Long, who is our current hospital administrator, reports directly to Mr. Russ Williams. Mr. Williams is the regional hospital administrator, and so Mrs. Long hires and fires and selects her people on the hospital side, and I essentially do the same on the medical group side, that is, the doctors, the nurses that work in the clinic and so forth.

Huth: And the health plan managers?

Shragg: The health plan is a separate thing. I would submit that if the doctors in the medical group were totally unhappy with the hospital administrator, we could bring some significant pressure to bear to make some changes. But I don't have any direct input on selection or appointment decisions.

Commitment of Medical Directors to the Medical Care Program

Huth: You mentioned something about Dr. Jack Smillie starting a program of annual meetings for medical directors.* Can you tell me something about what you consider valuable about that?

Shragg: It's very valuable to the extent that it provides a forum for us to get together periodically to at least verbalize some of our concerns and experiences. And it enhances our togetherness, and it's important. Dr. Garfield, above all, emphasized the absolute requirement that we do this, so that, to quote him, "the Kaiser Health Plan doesn't split us apart and take over the medical groups." That the "strength of our program is that there be an autonomous, strong, independent"--to that degree, at least--"medical group, along with the independent health plan and hospital," and that "one ought not to totally prevail over the other."

Resistance to Kaiser Industries' Control Attempts

Shragg: There was a definite attempt--according to his recitation of the early days in northern California, corroborated by Dr. Morrie Collin, Dr. Cecil Cutting, and Dr. Wally Cook--on the part of Henry Kaiser, Sr., to split the medical group as it existed then, and conquer them--take over.** Mr. Kaiser was a person, I'm told, that liked to control everything and not have to be responsive to anyone.

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*John G. Smillie, M.D., The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985-1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

**Morris Collin, M.D., The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1986-1987, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, in process.

Cecil Cutting, M.D., The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985-1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley. 1986.

Wallace Cook, M.D., The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1986-1987, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

It was certainly the case in the early years. As a matter of fact, there's a Dr. Russel Lee, who was the founder, I believe, of the Palo Alto Clinic—a very prestigious medical group in Palo Alto. He—I think it was in the Group Health Association of America, if I'm not mistaken—but, in one of the national groups—gave a lecture one time, and there was an award to him. And he mentioned that he was approached by Henry Kaiser as to whether there would be a desire on his clinic's part to associate with Kaiser.

The bottom line was when Dr. Lee, one of the founders of the clinic movement—his wasn't prepaid at the time, although it involves prepaid now—said, "Well, who's going to control the doctors?" And Henry Kaiser allegedly said that he would. And Dr. Lee thanked him and bid him goodbye. And there was an attempt to do this in northern California. Dr. Wally Cook was involved in that when he went over to the Walnut Creek area and so forth.

Dr. Garfield gave us this talk and some background and some personal comments about the early days, and the desirability, and the absolute need, in his judgment, to have the physicians stick together in some kind of group. The on-going meetings between the medical directors is an outgrowth of that and Jack Smillie's personal efforts in getting this off the ground.

Huth: Do you know what year that started?

Shragg: My guess would be in the very early '70s. I know Jack can tell you that.

Huth: I interviewed him, and I don't remember that he mentioned that. I'll check back on that.

On Limiting Membership and Setting Rates

Huth: Do you have any input into the establishment of health plan rates, since it has a lot to do with the medical program?

Shragg: Well, the only input we have is through recommendations we submit to Dr. Murray. Presently, it is based on what we perceive our needs to be, people-wise, for equipment, etceters. It's the regional office's responsibility to try to collate that together—agree or disagree on the various requests from the areas, and then that's submitted with the health plan and hospital requirements, and that's translated into "dues."

Dr. Frank Murray—and Mr. Hugh Jones now, who is the regional health plan/hospital manager—his predecessors were the ones that came to grips with the dues rate. Hugh Jones has just recently come

aboard, having replaced Mr. Carl Berner who recently died. They write the agreement on the rates. Technically, I guess, the health plan has the responsibility to do that. They can do it unilaterally if they want to. If they got into some conflict, for example, it's their ultimate responsibility.

Huth: How does the health plan decide when and how to recruit members? Would the plan want to recruit members even if the medical group wasn't prepared with clinics and doctors? Does that happen?

Shragg: We have, by the medical service agreement--at least, in southern California--which is a contractual agreement between Southern California Permanente Medical Group and the Kaiser Foundation Health Plan--we have in that document--and I have the document here--a veto power over expansion if we perceive we aren't able to accommodate to it. [shows agreement] This is a current one, and let's see what it says.

It stipulates here that they can't unilaterally go out and recruit members without our concurrence.

Huth: That answers that question.

Would the members come first, before facilities were built?

Shragg: That's always been the case, yes. We're always behind on facilities and staffing for them, unfortunately.

Huth: Is the health plan always causing a catch-up situation,--where it's got more members than you can handle?

Shragg: Yes, there are always more members than we can idealistically take care of. [leafing through contract]

Thoughts on Cost-Cutting, Good Facilities, and Quality of Care and Service

Huth: Speaking of the limitation of supplies, did you ever hear the story of what happened up in northern California and about the Pencil Stub Club?

Shragg: No.

Huth: That was when Sidney Garfield demanded that, to get a new pencil, you had to bring in your stub?

Shragg: Oh, yes, I read that.

Huth: So they have formed what they call the "Pencil Stub Club," and it's all the people that were there at the time that was in existence.

Shragg: Oh, really [laughs]. I heard that Sidney Garfield was pretty tight on that sort of thing. But in his own way, I can tell you he liked nice things, whether it was hotel rooms, or meals, or, you know, those kinds of amenities.

Huth: The perks.

Shragg: Yes, the perks. And he deserved them, I must say. We had a special incident with him that involved Dr. Wallin, myself, Dr. Sidney Sharzer, and Ernie Erickson, who was then the hospital administrator at Harbor City, where we needed some expansion. We had put together what we perceived to be the best way to go in terms of the expansion of the physical facilities at Harbor City—we needed more operating rooms, a recovering room, and a few other things—Ob [Obstetrics] expansion and so forth.

Dr. Garfield, at that time, was still ultimately responsible for that. The physical facilities were not Dr. Kay's highest priority in terms of interest. He obviously wanted appropriate, good quality facilities, but he didn't get involved in the detail that Dr. Wallin did, for example, and others. His focus was on staffing, and doctors and so forth. We went up to northern California, the four of us, to meet with Dr. Garfield to present our thoughts to him and our recommendations for expansion to cope with the needs of Harbor City.

Our proposal was at odds with what Dr. Garfield thought we should have. One of the things that he was at odds with was our use of the existing operating room. We wanted to convert it to an Ob delivery suite, which we needed desperately, and create new operating rooms and new recovery rooms and so forth. Dr. Garfield had other ideas, and one of them was to build a new delivery suite someplace, and not to come up with our recovery room needs to the extent that we felt that they were necessary.

When we had this conflict, Dr. Garfield tried to get Dr. Sharzer—who was our chief of Ob then—on the side, to try to sweet-talk him and bribe him into agreeing with his proposal rather than with the proposal that Dr. Wallin, Dr. Sharzer, Mr. Erickson, and I had come up with. He was going to give him an extra delivery suite if he would just simply agree with his proposal. Of course, it's really ironic that he would even consider that.

Dr. Sharzer, of course, was aghast that Dr. Garfield would attempt such maneuvers to try to get people to agree with him. Dr. Sharzer did not agree with him, especially since Dr. Garfield's alternate proposal was not as good, in our judgment, as the one that we came up with in the first place. And in the end we didn't get

what we wanted. We didn't do exactly what Dr. Garfield wanted, either. There was somewhat of a compromise, but the unfortunate result of that compromise was that Harbor City is not as integrated a facility as it would have been had Dr. Wallin's suggestion been implemented.

That was just strictly because of the personality and stubborness on the part of Dr. Garfield, in my judgment, refusing to accept our goals. The long-term results are rather apparent to those of us who recall what our needs were at that time. And that's unfortunate, but I guess that goes on in any large organization. Personalities sometimes prevail over objectivity.

Huth: What happened as a result of the escalating costs of medical care that were much higher than--close to double--the rate of inflation in the late 1960s? What happened in your program? Did that have an impact that you observed?

Shragg: No. Well, our program grew by leaps and bounds in those years, as I recall, and we--having no competition to speak of, in terms of the prepaid field--I don't think it affected us. The only way it affected us was the need to try to be more competitive. And our salaries for physicians escalated significantly because of the competition and the need for recruiting, and to maintain some kind of balance with the staffing. But other than that there was nothing that we experienced adversely, in terms of what was going on in the medical community on the outside.

Huth: How did the group work to balance the need to keep costs down with the need to provide quality service? Weren't you always working to try to keep costs down?

Shragg: Well, we were way ahead of the field, simply because our hospitalization rate was so much less than it was in the community around us. So we had that major advantage, which no longer exists. In the last few years they've caught up with us. Our major financial advantage that we had was hospitalization. I don't think we had any significant advantage in terms of physicians' salaries. Certainly not in terms of the support services, because we were unionized, as a matter of fact. We were paying our nurses and techniciana much, much higher wages than in the community around us, and that has served us adversely in these current times.

So our major advantage was simply lower hospitalization rates. Dr. Gordon in the central laboratory, I'm sure, saved us millions and millions of dollars in terms of the overall efficiency of the laboratory program. I think our doctors were more productive because we had fewer doctors per thousand members than existed in the community around us. Our salaries as a group were also less than the average in the community, but we have caught up to the community in the past seven to eight years--with some exceptions in

some of the very highly paid specialties, like orthopedics. But that has dollar-wise, been diluted in terms of the size of our program. So individual orthopedists could and still can earn a lot more, but the average internist, pediatrician, primary care doctor's salary, I believe, now is as good as or even exceeds community standards, especially in pediatrics, and family practice, and general internal medicine.

Huth: Was a committee on the quality of care set up on the board of directors in southern California--based on a similar committee in northern California?

Shragg: That was in Oakland.

Huth: I thought that was also here.

Shragg: Well, there was a special committee in Oakland.

Huth: In 1984?

Shragg: Yes, that was in Oakland.

Huth: Okay. Did that affect southern California?

Shragg: The only way it affected us was it caused us more headaches and paper work. The quality of care issue is a difficult one, and nobody, I think, would argue with the need for quality of care. The problem is defining it and knowing what one compares it to. The biggest quality of service problem that we have is not the individual physician, or the nurse and the patient relationship in the hospital. I think that's as good, or better, than anybody provides. Nor is it in the doctor's office, generally.

Our problem is that some of the telephone services are not as good as they could or should be. And in certain areas there are delays in getting access to elective types of medicine, like routine physicals. But if you need emergency or urgent care, we are available. Those telephone access and delays in routine appointments problems are the areas that I think we are deficient in and have difficulty coping with. But in general, if you take the quality of the inpatient care, the surgical care, and ICU [Intensive Care Unit] care we probably are as good or better than the community around us, simply because we don't permit anybody in the operating room unless they are board eligible or board certified, and that sort of thing. The rest of it is personalities.

Huth: Carl Berner said in something that was written recently, "I think we have more work to do in the quality of service than the quality of care--much, much more work." Was he was referring to the quality of service by the doctors?

Shragg: Yes. I think he's referring to the telephone receptionists responding kindly and courteously, and other paramedical personnel being sensitive to presenting a caring attitude. One of the big problems there is that our people are unionized, and that makes it extremely difficult for us to cope with, certainly in a counseling mode. And certainly, if they're bad—in terms of termination--we ultimately should terminate these people, if we can't upgrade them. We are just hampered by that excessive restriction of having the union on our back. Not that I don't think there's room for unions, and not that I don't think that without them management, not us necessarily, but management in general, would not take more advantage of them. But I think there's an excessive amount of protectionism, and that they have changed that into something that's really ridiculous.

We had a tragedy in this hospital shortly after we were opened. One of our employees who had been terminated came in and killed our nursing director.

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That man subsequently came in and wanted to have it considered an industrial accident, simply because he said he was stressed and all that kind of garbage. My understanding is that there was some--at least weak--support by the union for his initial allegation. I mean, there's a degree of insanity that goes along with that kind of thinking.

Huth: How long ago was that?

Shragg: I think she was killed shortly after we opened—Diane Richardson, a lovely lady and a good nursing director. A real tragedy.

But Carl Berner was right--that our quality of service is very important, and that's a product of training, a product of upbringing, a product of education. There's a need for some discipline.

Huth: It is cultural?

Shragg: Cultural, no question about it. I mean, I know there are people who just can't be nice to people--some people just aren't, that's all--they have a lot of hostility. And I don't think it's unique to us; I think it's just our society around us, as well.

Huth: In the past few years. the last three or four years, Kaiser has expanded to other areas at a much more rapid rate than they did before. Have you been involved in any of the expansions to other areas? Were you brought in to consult on any of those expansions?

Shragg: No, I was not.

Recollection of Work with Program Leaders

Huth: Now I'd like to ask you a few questions that have to do with your relationships with people connected with the different programs. One comment that was made recently in something written about Kaiser was that "the key to our success is the people and the leadership they give." And that's what you've said, you've said that people were very important. Who would you consider were the inspiring program leaders in southern California? Have we thoroughly covered that? You told me about quite a few of them.

Shragg: Well, I think Ray Kay, obviously, was a unique personality. Dr. Baker—I think I've mentioned most of them, certainly in Harbor City I've mentioned virtually the majority of them. I think we have Dr. Klitsner, my cousin Bob--various medical directors who I think were leaders. I think Dr. Murray is just doing an outstanding job. I think he's the right person for this organization at this time. I think Dr. Kay was at his time. I think Dr. Herman Weiner, who replaced Dr. Kay, was weak and ill, unfortunately, and Dr. Baker took over--people just kind of filled in at the right place at the right time—I'm convinced.

On the health plan side of it I think you have to mention Mr. James Vohs, who obviously was a leader, as was Carl Berner.

Daniel Wagster and James Smits

Shragg: I, however, don't believe that Dan Wagster was quite the leader that they were, at least in southern California. This was certainly true when it came to facility planning. I don't believe he had the same vision regarding the facility needs of the program. As a result we fell farther behind than we already were, creating greater hardships for our staff and our health plan members. It also proved to be more costly in the long run, I believe. It was also easier to relate to some of these people than to others. This applied more so to those that worked for them than to me, since they could not terminate me.

It is interesting to observe the interactions of the employees with their bosses in an informal setting. such as on a golf course where everyone is more relaxed, in contrast to the more formal setting in the office or workplace. Communication and positive relationships are enhanced in this informal setting, and I believe it carries over, more or less. depending on personalities. to the workplace.

I saw this more commonly with these senior managers of the health plan and hospital. These relationships within the medical group were much more relaxed. And yet they were all basically good, friendly and well meaning people, wanting the program to succeed as much as the medical group wanted it to succeed.

I had an advantage over some of these people because Jim Vohs, Carl Berner, and Dan Wagster, Ray Kay, Jack Mullin--Jack Mullin is an important person--and I used to play handball together, so we could see each other, you know, naked. literally. Somehow that improves relationships between people. If we could get some of those people to get rid of their neckties and uptight collars, and give them an opportunity to play a game with us—I think maybe our relationships and perhaps their relationships with their own people could improve. People would be more relaxed; I think we could get things done better. For example, Carl Berner was much less formal and openly more friendly. He would sit in meetings with his necktie and shirt collar loosened. His associates and people he interacted with appreciated that. It led to more openness, better communication. and probably enhanced the respect that people had for him personally and for his leadership.

Huth: Where did Dan Wagster go from here?

Shragg: He went to Portland. Oregon, as a regional manager, and now he's being transferred to Oakland as one of Jim Voh's assistants. But I know people who worked for him were terribly afraid of him, which does not make for a good relationship. Very difficult. I wish I could explain his personality. He turned out to have been detrimental to southern California, and most certainly in terms of facilities expansion.

Do you think I have to take that out of my history? [laughs]

Huth: Well, you can decide whether you want to or not.

Shragg: That opinion about him is not mine alone, I can tell you that.

Huth: Would you care to say anything about James Smits? Did you work with him?

BOARD OF DIRECTORS,
Southern California Permanente Medical Group, about 1977.

Seated left to right: Drs. Kenneth Bell, Irving N. Klitsner, T. Hart Baker, Oliver Goldsmith, Ester Fiszgop, Frank E. Murray.

Standing left to right: Drs. James D. Roorda, David B. Myers, Tado Sato, Raymond Lesser, Robert I. Shragg, John J. Kondon, Irwin P. Goldstein, Michael F. White, Irvin Roger, Lewis C. Hahn, Harry Shragg, Frank Fletcher, Benjamin Rubinstein, John Miles, David Potyk, Herbert J. Sorenson, Irving L. Applebaum, Joel Satzman, Charles N. Sadoff, Walter R. Groeber, Chester A. Haug, Arthur Starr, Martin Bauman.

Shragg: Yes, I worked with Jim Smits. Jim Smits was a nice man. He was not a very forceful person; I think he was very knowledgable in his field of hospital administration. He was not a pusher in the sense of really getting things moving—whether you agreed or disagreed with him. He was a nice man, he was, again, very good for us politically because he was known in the hospital administration community.

John Boardman and the Same Day Admittance and Surgi-Center Concept, 1964

Shragg: A guy that I worked with that I thought was a very good guy and very important was John Boardman. Unfortunately he died at a very early age. He was the hospital administrator I worked with at Harbor City, and I think he was a leader and a real comer in the organization. He died tragically too young. We didn't agree on everything, but it was a respectful disagreement. People liked working with him. He and I started the same-day surgery program for all of southern California. We didn't know what we were doing in terms of what the future was. We just did it because it was the right thing to do.

Huth: What does "same-day surgery" mean?

Shragg: We started same-day surgery in 1964. Patients came in in the morning for relatively minor surgery. The procedure was: They would come in, be operated upon, and go home the same day. That was many years before the development in the community of surgi-centers, which was another way of providing good quality care at more economical prices and to save hospitalization.

We did it out of necessity. We just did it because, in Harbor City. the operating room was around the corner from the emergency room where we had a few beds that were always crowded. It just dawned upon us to do it because it was okay, medically speaking. Mr. Boardman then checked to see whether we could do it legally. He checked with Russ Williams. He was then the hospital administrator at Sunset, who thought that it was not legal to bring somebody into the operating room without actually admitting them on paper as a hospital admission.

John Boardman researched it and found out that we could do anything we wanted, medically speaking. as long as the patient didn't stay past midnight. So we could therefore take care of patients on an out-patient basis, more economically, without sacrificing quality of care, and we started to do that out of necessity. Then. when Dr. Wallin went to Bellflower, and then

subsequently to San Diego, he took the idea with him. They had more beds; they could expand the program, and now everybody is doing it. It's the "in" thing.

John Boardman was a good guy. He went on to replace Mr. Smits in facility planning, at least. And then he went on to Denver as the regional manager there. I'm just not sure of the sequence of events. Then subsequently he moved to Oakland to a job in the Central Office, and then just tragically he had a heart attack, I guess.

Huth: How long ago?

Shragg: God, it must be five, six years ago. He was, I think, forty-nine years old. John was a forceful leader, a good leader, and I enjoyed working with him.

Working Informally: Intangibles and Innovations

Huth: Herman Weiner had a comment about the Southern California Permanente Medical Group, and what he said is: "The crucial elements about the medical groups, their relationships to member physicians, the hospitals, and health plan, cannot be charted in a table of organization. Our essential modus operandi is the interaction of a series of intangibles." In essence, he thought that you can't put this on a chart and chart it out.

Shragg: [chuckles]

Huth: There are so many things involved in it. One of the things we've heard about, is that there's an informal method of working that seems to help make things work better. Have you found that that's true in southern California?

Shragg: Informal, between who?

Huth: Meeting for lunch to solve problems, or calling someone up to help you get to things, rather than following an organization chart and a rule that says you only do it one way and not another way.

Shragg: Well, you're absolutely right, and I think most of the things that we get done we get done on a one-on-one basis, informally or formally. And it's on the strength of personalities and, I think, mutual trust that we develop. That's why I say that I think it was important--my playing golf, or racquetball, for example--with these people that I mentioned. And that's an intangible.

I think what's happening as we get older and more structured, and we get all sorts of organizational so-called experts involved, is that we get what Jack Gordon always said--we get "hardening of the categories." The tragedy is that it becomes less effective and less personal. So it depends almost on who you know as much as what you know that can get some things done. And I think we have too many study groups and task forces, and less risk-taking on a one-on-one basis like Dr. Wallin used to do.

For example, in Harbor City, Dr. Wallin and Dr. Bill Fawell, an internist, were the first ones in the whole group to see the potential for a home health service, of trying to provide some health care in the home, without keeping these patients in the hospital. Dr. Wallin met with all sorts of resistance in the regional offices, and without telling anybody, he just authorized Bill to go back East, I think, to Maimonides Hospital in New York City, where they were starting to write about those things. We just sort of did it at Harbor City, without any sanction, or budget, or knowledge, and it just worked.

And when Medicare came along in '65, and suddenly that became one of the "in" things to do. Buck Wallin had a lead on it, and we simply expanded that program. Unfortunately, Dr. Weiner, who had been very negative about Dr. Wallin's idea, grabbed hold of it and ran with it and expanded it to other areas--to Sunset. I think Bill Fawell and Buck Wallin didn't get enough credit for what has turned out to be a very positive part of our program.

It's that sort of thing that is difficult to do now in our organization, to be creative and try something--even if it fails. It's part of our being big, and we have too many boxes where people isolate themselves in a box, and they report to somebody with a solid line or a dotted line. Everybody knows who their boss is, I know who my boss is, and I don't have to have a piece of paper that shows it to me. I think we need to know more about how to build relationships.

On Irving Klitsner, Jack Gordon, and Ira [Buck] Wallin

Huth: What can you tell me about Irving Klitsner?

Shragg: Well, Irv is a close friend of mine, and a more dedicated person I don't think you'll find--to the concept of the program--historically, or in any other way. He was a very good, competent pediatrician, and that was true over the years, as he became involved in administration and helped develop the Panorama City area. The hospital itself finally opened up in 1962, but he was

doing the same thing prior to that that I did—in going through the Inglewood, West LA phase of development--and he was putting together an excellent staff at Panorama City.

When he got more involved with administration, he designed and pushed for a program identifying the needs of teenage people, which was then in its early years of recognition. The program recognized that these young people needed a specialized kind of care and consideration. Irv was one of the pioneers in that area, and he still is. So he kind of devoted himself to that aspect of pediatrics--pediatrics having expanded from maybe fourteen to eighteen years of age to that area in between in adolescence, where patients are no longer really children and they're not yet total adults.

So Irv devoted himself to that as he got involved more with administration. Then he transferred to the regional office to become an assistant to Dr. Baker, when Dr. Baker took over from Dr. Weiner as medical director when Dr. Weiner retired--or was disabled, I should say. Irv is probably the best organized person that I know--at least in the medical group, structurally speaking. He's persistent in going through the details and the minutiae necessary for some administrative things that I personally abhor and can't cope with. A very caring man, who--as I say, there's no more devoted person to this organization and kind of program than Irv Klitsner.

Huth: And he's been in it for a long time?

Shragg: Oh, he's been in it since the days of Jack Smillie. He started up in northern California before southern California was really in existence. So he, I think, started in '49, if I'm not mistaken.

Huth: Jack Gordon.

Shragg: Well, Jack Gordon is one of my all 'round favorite people. I knew him as a child, when he and I were growing up, even though he was a few years older. His family and my family lived very close to each other--we played together, went to school together. We worked together. I used to work for his brother, and his older brother and his brother George and I worked together as ushers. We're really, again, I would say we're really family.

Jack was a tremendous athlete, and he still is. But I mean in his younger years. Always poor--his family was always poor, and going to school and supporting himself through college was a major effort. Always working, and always motivated. Jack, when he finished pathology, went down to Fort Dodge, Iowa, as a pathologist, and the town then had two hospitals: a Catholic hospital and a Lutheran hospital. He worked for the Catholic hospital.

The kind of man Jack is is exemplified by the true story, that while he was in Fort Dodge, Iowa--and the town had never had any pathologist in residence--they would send their tissue and so forth to Des Moines, or Iowa City (one of the major cities there) for examination. So Jack, who was then asked by the Lutheran hospital if he would at least do their frozen sections for them--that is to say, the immediate tissue examination for surgery--he did. For which--I guess, this is 1948 or '49--they paid him a sum of, I think he said, $600 a month, which was, even then, a lot of money for doing very little work. And Jack turned the money over to the hospital, simply because he felt that he was making, by then, a lot of money--by those day's standards, and certainly by his background's standards--and he felt he owed it to the Sisters to return the money to the Catholic hospital, even though I don't think he was legally obligated to do it.

Huth: Did he see a special need there, do you think?

Shragg: Well, he was just a responsible person. His total work, he said, for the whole hospital only took him an hour a day. He's one of the fastest, most accurate, highly motivated workers I have ever known in my life. I mean, he just can't sit still. He does a lot of walking as an on-going exercise, and while he's walking he has to be reading. He's compulsive about utilization of time. He will use his time while walking to read, or to keep up on things.

It's exemplified by when he was the only pathologist in southern California, and I remember he came to see me--he came to see his family of course, but me too and others in terms of recruiting in Minneapolis. He said he had to have somebody replace him while he was gone. And he had called UCLA to see if they could find somebody who would work, and Kaiser Permanente would compensate him, of course. They said that, considering the volume of work that he was doing, they would have to hire four people--and he thought he was being underworked. He could work an hour a day because he had good people working for him. His whole premise was that he had highly paid loyal people, like Mr. Harold Cohn, who's now running the laboratory.

When a colleague of his, Dr. Ellis Benson, who was at the time head of the laboratories for the University of Minnesota, was out here for a meeting, and Jack and he were talking about their comparable programs--they're both into laboratory medicine and pathology--at the time, I think, Jack told me that he had seventeen pathologists in Kaiser Permanente. That is the total. Ellis Benson said that for the same amount of work, and the population that we were serving--in the state of Minnesota they would need seventy-one pathologists, something like that. Just an enormous difference.

Huth: And that's his organization?

Shragg: That's all due to Jack Gordon. He just never thought it was important to waste time or money or people. He felt that if you're there eight hours a day you work eight hours a day. and pathologists. by and large. in community hospitals, have a reasonably leisurely life because their incomes are okay. Now, maybe that will turn around because there's a lot of pressure on them.

Huth: Where is he now?

Shragg: Jack? Jack is the all 'round utility infielder. He goes wherever they need him, so he works two days a week in Bellflower. and he goes to Sunset, and he comes here--he just goes all over; he just can't sit still.

Huth: He's not retired?

Shragg: No. no. He's an ex-partner, but retirement is not for him.

Huth: He's old enough to retire.

Shragg: He's sixty-seven or sixty-eight perhaps. He's so compulsive he can't take vacations, or when he does, he gets bored. He's just not a person that knows how to relax in that manner. He's just a sensational person.

Huth: How about Ira [Buck] Wallin?

Shragg: Well. Buck is a maverick. I recognize his frailties and the reservations that other people have about him, but I don't have them. I can accept him as he is. He's a little nuts at times in the sense of his interactions with people. He's an anarchist in many ways. and yet, with that, his devotion to people and patient care just cannot be challenged. He is a man full of ideas. Again. if we gave him a chance he could do more things, but in that sense, obviously, he's his own worst enemy because there is some need for some organizational togetherness required. and Buck has a problem with that.

My wife asked about him when we were talking about this and we couldn't figure out how Buck ever came to Permanente. But at the time he came, Ray Kay asked him to help start the Harbor facility. So that was a new challenge. It was brand-new. Permanente was in its infancy, and to that extent he did a whole lot of things. I think he alienated some doctors because of the way he worked, which was that he might come in ten o'clock in the morning. and people would look upon it as being lazy. But they didn't realize that he would be working late into the evenings--and he had his own way of operating as an administrator. He developed and opened the

Bellflower area and subsequently the San Diego area when we took over the San Diego Health Plan, a group of about twenty-five physicians who wanted to affiliate with Kaiser Permanente.*

When Buck was seeing patients, many of them were people that had the heaviest charts, which was a measure either of chronicity of illness, or hypochondriasis, or difficulty in relating--Buck attracted those people. He was very patient with them; they loved him as a doctor. When he was replaced at San Diego as the medical director there, he moved up from San Diego and worked in our outlying clinic at Inglewood as an internist after he had some retraining. The patients just loved him--he's just a good person.

And I owe him a lot, I think, in terms of this organization--just in terms of his being a role model for me in many ways.

Huth: He's the one who hired you?

Shragg: Yes, he was the medical director that confirmed my hiring--he and Dr. Peter Eastman, I guess. Although I had sort of had it promised to me indirectly from Ray Kay through Dr. Gordon when he came to see me in Minneapolis.

Huth: Where is he now?

Shragg: Dr. Wallin?

Huth: Yes, Dr. Buck Wallin.

Shragg: Who the hell knows? [laughs] He's a hard guy to find. But I'll try to reach him for you because I think he's an important person in the history of this program.

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*Dr. Kay needed a medical director to go to San Diego to develop that area. Our Permanente Medical Group board of directors voted to go to San Diego only by a majority of one vote. There was a lot of resistance on our part to expand that far away. But it is quite possible that without Buck, who was the only experienced person willing to move there, we might not have expanded to San Diego. Without him, we certainly would not have been as successful there as rapidly as we were.

V OVERVIEW OF THE KAISER PERMANENTE MEDICAL CARE PROGRAM

Reflections on the Role of Physician Administrators

Huth: What makes a good physician, and what makes a good administrator? Should they be good at both, and who's the most important person to the program?

Shragg: I think you need the same qualities in both, and that means really being a caring person, caring for patient care. I think that's the paramount ingredient. And to be sensitive to, tuned-in to listening to patient complaints, patient concerns. The frustration of being a physician and an administrator is the inability to necessarily rectify all the needs of all people. That's the on-going challenge.

The most important thing for a physician is to be that caring person. If you're not, the tragedy is that not only do you get the task of patient care, but I think the physician misses the fun, and the joy, and the ego satisfaction of patient care, which is the part that I miss, of not being involved directly with hands-on care of patients. I enjoyed that--was frustrated by it--but my personal ego rewards were certainly greater there than in administration.

For an administrator the most important thing--if you're talking about physician administrators--is that he or she be, number one, a good physician. I don't think you can be a good physician administrator without being a good doctor in the first place--one that is respected by your colleagues as a good physician. Otherwise I don't think that they can respect you as an administrator. And that's the conflict between physicians and non-physicians in the field of administration, because the perception is--and I think it's to a significant degree correct--that administrators do not know what the defined product is--that is, the bedside care, the giving of enemas, or applying of nasogastric tubes, or being sensitive to and having experienced patient needs and personal needs, day and night, seven days a week.

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Shragg: It's always helped me to be able to go down and see patients once in a while with a white coat on, and for the other staff doctors to know that I'm a physician first and an administrator second. Admittedly, I have problems now with those who've never seen me practice. And the older physicians, who have seen me practice have frequently countered some concerns expressed by younger physicians with the comments that, "at least, I used to be a good doctor." And I hope to reestablish that once I get through being an administrator.

But the conflict between physician and non-physician, as I expressed earlier, is exemplified mostly on the hospital administrator's side with Mrs. Long, a nurse, as distinct from previous hospital administrators without medical backgrounds--who were good hospital administrators as administrators go--but I can tell you that they just don't have quite the feel for the need for patient care, the kinds of concerns that Mrs. Long and I have, or are expressed by other doctors. As to Mrs. Long, it's simply because she has experienced those things and she identifies with them. Again, it's not to denigrate the others, it's just that their backgrounds and training just don't lend themselvesto the same exposure to patient care that they have with me or with Mrs. Long.

Huth: Do you think that your training as a surgeon helped you as an administrator?

Shragg: Oh, I think so. I think the discipline of surgery, and perhaps the need to make decisions even though they're bad—I mean difficult [laughs] decisions (they may be bad)—at times, at least I'm told that with that personality trait I've been able to cope with making tough decisions. The tough decisions mainly are people decisions: the need to counsel, or criticize, or push for, or fight for things that I believe are necessary for a variety of reasons.

Huth: Do the developed skills in one area carry over to another?

Shragg: Probably. I certainly can identify with the physician as well as the administrative needs that are required, in terms of the bureaucracy, government interference, government imposition. So I think I can bridge the professional and administrative side; at least that's our biggest, toughest job.

On Leaders in the Northern California Central Office

Huth: Would you care to comment on any of the people that were up in northern California? I'm thinking of people like Henry Kaiser, Sr.,

Edgar Kaiser, Dr. Clifford Keene--some of the people who worked out of the Central Office or were related to Kaiser Industries.*

Shragg: I didn't know Mr. Henry Kaiser, Sr. I met Mr. Edgar Kaiser a few times--just under more social conditions, not in any working relationship. I was always impressed with him, what a kind, nice man he was, and down-to-earth person--for somebody with his international reputation, and he was a charismatic person.

Cliff Keene I knew also somewhat casually, but I saw him a little bit more often as he toured Harbor City, and a couple of times I talked to him when I was up in Oakland. He and I got along very well and we formed a casual acquaintance, and, I think, certainly with mutual respect on my part. I had heard some negative comments about him in the early days, conflicts between him and some of the other physicians, but I personally had not experienced that.

The person I probably saw more of, from the northern regional office that I was most impressed with was Art Weissman. He became a personal friend after some years of casually knowing him, and we had a lot of things in common just on a personal level. He's somebody the program obviously misses, in terms of his wisdom and his expertise, and his ability to communicate on a non-emotional level. I've never seen anyone else like him, who commanded the mutual respect of anybody who came within his sphere, even if it was a casual acquaintance--how impressed they were with him, and how important he was to this program at that time.

I met Avram Yedidia, who I know has done a lot of work within the program, and who, I guess, is an outside consultant.** He's another person very much like Art Weissman, and the program was enhanced by people like this. There are people up there, Bob Erickson and Walter Palmer, who are most impressive in terms of their knowledge. They're really smart, nice, important people--we might have differences of opinions, but that's really unimportant. Their capabilities are really impressive, as is Jim Vohs. I think Jim is a very impressive man; he's learned and grown a lot. I think he's done a good job, by and large. Again, he and I, having played handball together--

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*Clifford H. Keene, M.D., The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985-1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1986.

**Avram Yedidia, The History of the Kaiser Permanente Medical Care Program, an oral history interview conducted 1985-1986, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1987.

Huth: That helps.

Shragg: Yes. He's a very reserved person, not as, perhaps, loose or casual as I would like to see him, but somebody that I think is impressive, and I respect him a great deal.

Huth: How about Eugene Trefethen, did you ever meet him?

Shragg: I never knew Eugene Trefethen; I just heard of him. Dr. Wallin, if you ever find him, knows him, but I've never known him. I think I met him once, and that's about the extent of it.

Huth: Did you ever have anything to do with the Kabat-Kaiser Institute?

Shragg: No, never. I used to refer cases to them, but I had no personal experience.

Huth: Rene Caillet?

Shragg: Dr. Caillet, who I guess was there before he officially joined the Permanente Medical Group, was and is an internationally renowned physiatrist and very important to our program, in the sense that he was one of the early physicians involved with helping to plan West LA as a consultant while he was attached to our Sunset facility, and the leader of the physical medicine and rehabilitation program for all of southern California.

Huth: Did you know Dr. Garfield or Dr. Cutting?

Shragg: Yes. Sid Garfield I met on numerous occasions, and, again, I think I mentioned the one experience I had with him, the conflict that we had. But he was a man most to be admired and respected, in spite of that difference of opinion he and Dr. Wallin had, really, not me--I was just a little flunky then. A caring person, and a charismatic man--obviously without whom this program would not be here--and a very creative and innovative person.

I think it's difficult to make things move within our program because we are now so structured and so big, and we need more Garfields, and Buck Wallins, and Ray Kays to continue. We have to be more creative and innovative. It's harder to do these days with all the external forces that go along with it.

He was a charming man, Sid Garfield, and I'm certainly grateful that I had occasion to know him, even casually. And we need other pioneers in this organization.

Huth: Do you have any comments about the growth of the Central Office in Oakland? It's grown in size and responsibilities; it's taken on more and more. It's taken on research, for instance, and they're

S.F. Chronicle

May 14, 1986

Dr. Cailliet's Books on Pain

Dr. Rene Cailliet simply writes the best books available on orthopedic pain. Although he writes for the physician and the physical therapist, his succinct writing style and excellent anatomical illustrations make these outstanding books for the layperson.

Cailliet's concise descriptions of the diagnosis and treatment of painful and disabling conditions cannot be found elsewhere in such accessible format.

Among the most useful of his books are "Low Back Pain Syndrome"($12.95), "Neck and Arm Pain" ($11.95), and "Shoulder Pain" ($10.95).

But "Understanding Your Back Ache: A Guide to Prevention, Treatment, and Relief," is his most useful book on lower back pain. Cailliet talks about therapeutic exercise, special tests (when, why, which one?), chronic low back pain treatments (acupuncture, drugs, surgery), the psychological benefits of back pain, and how to prevent further injury.

Low Back Pain, Neck and Arm Pain, Shoulder Pain, and Understanding Your Back Ache: A Guide to Prevention, Treatment and Relief, 1984; $10.95 from F.A. Davis Co., 1915 Arch Street, Philadelphia, PA 19103-9954.

West Los Angeles Coverage, a publication for the employees and physicians of Kaiser Permanente in the West Los Angeles Area, February, 1985.

Sidney R. Garfield, MD

1906 — 1984

"Dr. Garfield was a true pioneer in the history of American health care."

Sidney R. Garfield, MD, physician co-founder of the Kaiser Permanente Medical Care Program, died in his sleep early Saturday morning on December 29 at his home in Orinda, California. He was 78.

"Dr. Garfield was a true pioneer in the history of American health care," said James A. Vohs, Chairman and President of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals.

"We are indebted to Dr. Garfield as Kaiser Permanente's co-founder for demonstrating that the concept of a prepaid health care delivery system is both practical in application and supportive of the highest standards of quality medical care," Vohs added.

Dr. Garfield was born April 17, 1906, in Elizabeth, New Jersey. He earned a BS degree from the University of Southern California in 1924 and his MD degree from the University of Iowa Medical School in 1928. He completed internship at Michael Reese Hospital in Chicago and at Los Angeles County Hospital.

Dr. Garfield's first hospital at the Los Angeles Aqueduct construction site in California's Mojave Desert, 1933.

After completing his residency in surgery at Los Angeles County Hospital, during the depth of the Great Depression in 1933, Dr. Garfield contracted to provide industrial medical and hospital services to workers building an aqueduct across the Mojave Desert from the Colorado River to Los Angeles. He borrowed money to build a small hospital that could be moved on skids across the desert as the construction site progressed westward.

He soon found himself near bankruptcy operating on a fee-for-service basis. After negotiating a prepaid contract with the industrial indemnity insurance company for industrial care and obtaining permission from the construction contractors to offer prepaid health care to workers through payroll deductions, Dr. Garfield was able to pay off his loan and expand his staff and operations.

His success with group practice prepayment attracted the attention of Henry J. Kaiser and his son Edgar, leading to their lifelong association and the development of the Kaiser Permanente Medical Care Program.

From 1945 to 1952, Dr. Garfield oversaw the Program's operations. In 1952, following implementation of the concept of separate and independent Permanente Medical Groups, Henry J. Kaiser appointed him medical director of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals.

Dr. Garfield served in that capacity until 1958, when he was named vice president of facilities for the organization and a member of the Board of Directors. He retired as a vice president in 1969, and from the Board of Directors in 1971.

Most recently, Dr. Garfield was chief investigator of the Total Health Care Project at the Kaiser Permanente Medical Center in Oakland, California. The pilot research project funded by grants from Kaiser Foundation Hospitals and The Henry J. Kaiser Family Foundation involves physicians, health educators, counselors, nurse practitioners, and other health care providers into a team emphasizing health promotion as a component of medical care for the patients being served.

He wrote numerous articles and books on health care, primarily on prepayment systems, health maintenance, health testing, and health promotion. He received many awards, including the prestigious Lyndon Baines Johnson Foundation Award for significant contributions in the field of delivering health and medical care services, and the Distinguished Service Award from the Group Health Association of America.

"Dr. Garfield's contributions to our Program and to medical care in the United States are beyond measure. All of us associated with Kaiser Permanente are indebted to him for his vision, for his leadership, and for his untiring commitment to our Program," said Vohs.

Early Permanente physicians (standing, from left) Fred Charles, MD, (former associate medical director, Southern California), Wally Neighbor, MD, Sidney Garfield, MD, (seated, from left) Raymond Kay, MD, (former medical director, Southern California), and Rick Moore, MD, gather in Orinda, California, 1949.

Friends remember

"To him, good care of the patient was the ultimate objective of the program," says Raymond Kay, MD, one of the early Kaiser Permanente physicians and a close friend of Dr. Garfield. "The program that he developed is evidence of his imagination, determination, and administrative ability."

"From his early days of training, Dr. Garfield recognized the great value to both the patient and the doctor of having a group of doctors sharing the responsibility of the welfare of the patient," he recalls.

"To those who've worked with him, he was a warm, considerate, and inspiring man. An individual who could never do anything unkind or unfair," said Dr. Kay.

"He was one of the first people who recruited me," said Irving Klistner, MD, Panorama City medical center, of his association with Dr. Garfield. "I was impressed by the caliber of his person and his interest in doing what's best for the patients.

"I remember I spent a year in Northern California, around 1950, just bulling with him (and some of the other early physicians) just talking with him and finding out if we all believed in the same things, the same philosphy of delivering health care. We found out that we all did agree," he said.

"There was one speech, years ago, to the medical directors—about the time everybody was calling us a bunch of communists—when he (Dr. Garfield) wanted us to remember three points that I'll never forget," says Dr. Klistner. "One, keep your eyes on the stars— meaning that there's nothing beyond your reach if you're sincere about your goals and you're willing to put forth the effort to get there.

"Two, keep your arms around each other—your colleagues are your friends. Stick together, have sensitivity about their problems. And three, keep your hands on your pocket book—keep expenses, costs down. Put something away each year (from your budget) so if you need equipment, you'll have it. That helped us all out when times were tough and we were all renegades in medicine."

Dr. Garfield served as vice president of Facilities for Kaiser Permanente from 1958 to 1969.

doing something now with client relationships and the medical care delivery system. That's something that Sid Garfield was interested in and Dr. Cutting is now working on.

Shragg: Dr. Cutting I knew probably casually, again, but as a quiet, reserved, important person, who obviously was in his own way creative, and a major leader of northern California. I didn't know him really intimately, but whenever he spoke, he was somebody worth listening to.

I don't know much about the Central Office, in terms of its size and scope, and I just have to expect that they have grown larger because of various external forces and needs. I can't really comment on that.

On Dorothea Daniels, Medicare, and Size as a Factor in Limiting Innovation

Huth: Did you ever work with Dorothea Daniels, who was a hospital administrator?

Shragg: I didn't really know her. I only worked with her indirectly and from a distance. I guess I didn't work with her. She was at the Sunset facility when I was at Harbor City, and I never worked with her on a daily basis. I can tell you she used to do things that would aggravate us, in the sense that she was a very forceful, dictatorial person—I'm told, very competent--but I can tell you she pulled one thing on me one time that I'll never forgive her for. That was at Sunset. She had a patient there, and I guess they had no beds, and she simply arbitrarily, unilaterally, put the patient in an ambulance, and sent him down to Harbor City. We didn't even know about it until the patient arrived on our doorstep. Just a total lack of courtesy in that respect. But she just ran a tight ship. I guess [laughs]. She would not tolerate all the side administrative garbage that now exists in all of our entities. She was just a dictator--I'm told.

Huth: Kept it going.

Shragg: Right, she kept it going. There are other people who could obviously tell that story better.

Huth: Could you say something about the Medicare program, and how Kaiser worked around the requirements? Was that ever anything that you were involved in?

Shragg: Well, I really don't know the total financing of it. I think that the Medicare people had a good deal with us. I think we were underpaid by the federal government, and I think there, again, some of the statisticians and administrative people that put it together never really understood or were sensitive to the intensity of the physician involvement on the in-patient side of taking care of these Medicare patients. That is to say, the reimbursement was based on an average: for example, one hospital visit per day. But with these patients it was frequently much more than that. They did not recognize the amount of extraordinary surgery, and anaesthesiology time and operating room time factored into it. So my guess is that the non-Medicare health plan member really subsidized that to a significant degree.

The only involvement that I had was in '65, when we got involved in it. At Harbor City we did a study to try to see what the factor was in terms of time required for Medicare patients, elderly patients in the office, as contrasted to the other patients. I believe we found a 20 percent factor for delays in time required to cope with these elderly people, and that was factored into the reimbursement formula--whatever that was. That's the only experience that I had with that.

Huth: What was it like to be part of a big bureaucracy? What was good about being big?

Shragg: I'm not sure there's anything good about being big. It was interesting to me when we went recruiting and I was recruiting somebody from the Lahey Clinic. At the time, the Lahey Clinic had an international reputation--the Mayo Clinic, Lahey Clinic, Ochsner Clinic--and I was in awe as a physician, of being in this mecca of the top medical care that was provided in the world. At the time, Harbor City had over one hundred doctors, and I was there, and at the time Lahey Clinic only had eighty doctors, and for me to think that I was, in a sense, responsible for a group of physicians larger than Lahey Clinic just blew my mind. Now that's big, and yet I thought that by our standards it was small because we knew everybody, and it was really more fun.

Huth: It's small by comparison with Sunset.

Shragg: Right, but certainly big by comparison with almost any other measure in the world in terms of the number of doctors.

There are pros and cons to a large group, one of them being that you certainly can get reinforcement and backing more easily and more readily. But I think it has it's disadvantages. The main disadvantage, I believe, is that you can't move things like we used to when Dr. Garfield, I'm sure, tried his innovative things, or Dr.

Wallin, or anybody else. I'm sure that if I tried to do this parent-child program now. that we did at Harbor City, it would just be infinitely more difficult.

That's the big problem. The day-to-day thing from a doctor's standpoint, I think, is totally unaffected. We think it is affected. but their involvement with direct patient care--how many patients they see, admission of patients, taking good care of patients--I don't think is really basically affected by this. It's other kinds of things, innovation, and creativity, and changing--if changing is desirable--that is difficult.

Impact of Mushrooming Health Maintenance Organizations [HMOs]

Huth: There are the new HMOs set up under federal laws. Would you like to say something about what you foresee for the future of Kaiser? And will you comment about Kaiser Permanente's relationship to this new push and so many more doctors going into prepaid medical care groups?

Shragg: Well, the idea is fine because I really think it provides an opportunity, ultimately, for providing better, more comprehensive care. We used to say, when we were practically the only game in town, that competition is good for us. I'm not sure that we would accept that any more because of the way that it certainly does threaten us. I think maybe to that extent it is okay.

The problem that I see with this extraordinary explosion is that now, in addition to the government putting on rigid rules, I think that organizations [HMOs] will always add their own rules on top of those of the government. In one specific case that I'm aware of and that a friend of mine was involved in, a patient really deserved to be hospitalized the day before surgery--rather than the morning of surgery, which is the trend nowadays. the sort of thing that John Boardman, I guess. and Buck Wallin, and I started in '64--and should have come in the day before because the patient had a terrible heart disease problem and required some additional hours of observation.

The DRGs [Diagnosis-Related Groups--under the new cost-cutting Medicare reimbursement system] or the Medicare rules would have permitted that, but now this other agency, another insurer, an IPA

HMO prohibited it in that particular instance.* That would not have happened with our group. If a doctor came to me and said, "This patient has a severe heart disease," we would have permitted that person to come in the night before. To that extent, physician involvement and control would have provided better patient care.

In that instance the administrator, just to save a buck--and I'm not opposed to economies--mandated that they would not pay for that extra day, so the hospital administrator, it seems, obviously wouldn't accept that either. I see that as the thing that is frightening about what's happening. I think it will maybe ultimately wash out as the Gray Panthers, and the AARP [American Association of Retired Persons], and others look into some of these real devastating effects on patient care. Again, that's my concern.

A friend of mine, who's also an administrator for a for-profit program in Florida---and he's a thoracic surgeon, and a very capable one--is just frustrated by what he knows to be good medical care being compromised in the interest of the almighty dollar.

Continuing Education and Personal Support for Physicians

Huth: Doctors are now given a week on educational leave, and more on request--I believe that's true in southern California, isn't it?

Shragg: They have one week of educational leave a year that they're eligible for. They also have the half-day per week in their regular schedule for education.

Huth: Would you care to comment about that provision for doctors--how valuable that is?

Shragg: Well, I think it's very valuable, and I think it's the one area where we obviously do better than doctors in fee-for-service, solo practice. Not that they can't do that, but it really represents a potential compromise on their part, compromising their office, or income, or time, for education. Here, they have to use their education time, or they have to work in the office, so the motivation is to be educated and keep up. I think it's an important benefit.

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*An IPA is a group of individuals contracting with an HMO and stands for Individual Practice Association. This is different than a group model or staff model HMO, such as Kaiser Permanente.

The one week of education a year, I think, is adequate, because they also have, depending on how long you've been here, several weeks of vacation. If somebody is really gung-ho about attending more meetings and so forth, I think they have to be willing to take it out of their vacation, or maybe even take a leave of absence without pay. So I don't have any problem with that. Obviously, many doctors want more time off, but there never seems to be enough, in terms of benefits.

I think we're very generous, and we're a very compassionate group. We are a very compassionate organization for our size, at least from a doctor perspective. We have doctors who have problems with drugs, substance abuse, and we provide an excellent support system, if we can and if they recognize and are willing to deal with their problem. If not, we have to get rid of them. But they are certainly better off here than they would be in private practice. It's an area of backing and support that is not written up as a benefit. I don't know how one writes it up, but it's one that I emphasize.

Young people, of course, don't understand it. But we have had doctors who have had malignancies, and where they get remissions and they feel better they come back to work. That's a tremendous support mechanism that could not exist if they were in solo practice, where once you got it--you're out. And here we have had doctors who have been ill who come back after six months. We give them some dignity, if they can perform their work. And doctors get crises in their families--injuries, illnesses--where they have to be gone for extended periods of time. We provide a support mechanism: when they leave, we take care of their patients; when they come back and they start to work again, they don't have to worry about their offices.

I just am very, very proud of that, and I think it started with people like Dr. Kay and others, who were caring, and it just evolved.* And as we got older and we got into more of these crises, we recognized how valuable this organization is. It's something, I think, one would not consider exists in a group this size. I can really speak to that personally from having watched it happen.

Huth: How about you and your family, and the care you receive? You must be members of the health plan. You must have used it for your own health care?

Shragg: We're automatically members. Oh, sure. My father, also.

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*Kay interview, Regional Oral History Office.

Huth: And your family's use of it--has it always been very satisfactory for you?

Shragg: Oh, sure. Obviously I have an advantage over any other average health plan member in terms of who I choose and how they relate to me. There's no question that there's some favoritism. I try not to take advantage of it, but it's inherent. It's just implicit in the organization. If they see my wife or my family, and they know it's a Shragg, obviously they'll pay a little bit better attention. The only resentment I have when they treat me that way is that I think they ought to treat everybody that way.

We had a funny incident with my wife. When I was at Harbor City she came in and checked in--and she really never ever has taken advantage of being my wife, in terms of appointments. I mean, I can arrange for an appointment, and that's easy and that's done. But she came in one day, and she just checked in, and it was a harrassing day for one of the receptionists down there. We were in the midst of turmoil with remodeling, and this woman was really a charming lady, somebody that we could kid with all the time--Dorothy Stafford was her name.

And my wife waited in line dutifully at the check-in with her card, and this woman was ranting, "Oh, if only administration knew about this, and that," and complaining and kind of just ventilating--

Huth: For everybody to hear.

Shragg: For everybody to hear. Then my wife came up and gave her the card, and she looked at my wife, and she was so embarrassed. My wife laughed, and said, "I'll tell my husband about the fact that you're upset with things, but not reporting her to me." When I saw this woman subsequently she turned to me, and she said, "Oh, God. I was just so embarrassed, Dr. Shragg."

But that was the fun relationship that you had--if you knew people. Nobody was really turned off by it.

So yes, we got good care. My dad has had some very serious illnesses, and injury, and operations, and he's just come through with flying colors. It's the quality of care that I would trust with any patient, not just my family. I think that's the ultimate thing. When I let my family do it, I have to believe in the system. Excuse me, it's not the system, it's the individual doctor, and the nurse, and relationships. People blame the system for good and bad, but the system only provides a mechanism for support for a physician, and again, it's the physician and patient relationship that is the ultimate thing.

They can do the same thing in private practice, so I don't like it when they blame the system for one thing, and they then compliment the system. There are some inherent things in the system--the telephone system, the largeness, that's tough. But when it comes to the bottom line, the patient care, it's really the individual and the availability of resources that count.

Quality Care for All: Union Member or Top Executive

Huth: One observer has said that Kaiser Permanente has been described as a working-class operation set up by the unions. They note that it grew around the large membership in the unions, and that a ward of eight people is likely to be predominantly working people. Would you think that observation is correct?

Shragg: I think the wording is correct. I think the connotation, and the implication of it is incorrect. I think, yes, it is geared towards working people, and perhaps people in the lower socio-economic levels who are employed. I find that to be tremendous because those are the very people that were previously denied quality health care. I think that to have somebody who has a lower level of employment, or even education, get the quality of care that he gets here, in terms of the expertise, is really something that I'm very proud of. I don't think that the Beverly Hills patient gets anywhere near the kind of care that we provide here. I don't care if they're working, or executives, or whatever.

I've seen executives get terrible care just because the patient has a reputation. I'm told that there are some doctors at Cedar-Sinai Hospital that in other hospital settings might even be terminated from a hospital staff, except that some of their patients are some major Hollywood personalities, and politically they can't do it--except in some cases when those particular patients of this doctor come in and they are assigned automatically to a better quality physician. That sort of thing.

It's hard to know, but I think the implication of that comment is not appropriate.

Huth: The implication was that perhaps if a person who was not in that working class was in a ward with eight people that he might resent it.

Shragg: Well, the fact is we have no wards.

Huth: There is no such thing.

Shragg: There is no such thing, and as a matter of fact, as I mentioned earlier, I think wards provide the best care. Actually the very best care. The sickest person, which is the person in the critical care unit, actually is in a ward, even though we may have glass around them.

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Shragg: So they know not from where they speak, or from whence they come because half of our rooms are private rooms, and the others are only two bedrooms. The only place where we have four beds is really in our special nursing care unit where people are comotose, or out of it and so forth. So we don't discriminate between the haves and the have-nots here. You get the room that's available, and depending on the nature of your illness, and not necessarily on what your pocketbook says, or what you look like, or anything else.

Prospects for Renewed Idealism and Innovation

Huth: In the old days when the program was small there was a cohesion, perhaps due to smallness and the doctors' idealistic drive. Do you think now because it is so large that some of the idealism has been diluted or disappeared?

Shragg: Absolutely. No question about it. I agree.

Huth: What are some of the major differences now, compared with the way it was when you came in?

Shragg: Well, I think the physician who comes now comes into a known entity. He comes in, and he wants a job--not that he's not competent, or good, or eager, or willing to give good care--I don't want to denigrate that. But we are now the establishment, and we are no longer the mavericks, so we are the "in" thing. And to that extent, as the establishment, we have the problems that all establishments have.

The next focus of change will be an improvement made by people who now take what is and make it even better, and again, that goes back to being creative and innovative and daring. Daring is really, perhaps, a term that is not used enough, and some of us think that we can't afford to be daring. But we are the establishment with the positive and the negative things that go along with being the establishment. We are the king of the hill, and people are out to knock us off the hill.

Huth: So that could cause you to become even better in the future?

Shragg: If we can respond to it in a way that still doesn't compromise quality care. If the almighty buck isn't the ultimate motivation--and not that finances aren't important--but the physician comes in here now because he's got a good job. a good position, a good professional life, a good income, secure--but not with the basic philosophy and some of the idealism that Dr. Kay, and Garfield, and others who started the program came in with. They were running contrary to what was then the establishment. That was the fun part of it.

Huth: Mavericks. in a way.

Shragg: Yes, that was the fun part of being in the group. It used to be when we'd go to parties other people would sort of--when my wife would say, "My husband's with Permanente," they would sort of look down their nose at that, you know, at least other wives and perhaps other physicians.

Nowadays, and in the last few years, when we say that, they say, "Oh, with Permanente. Isn't he fortunate; isn't that great; isn't that terrific." It's fun to sit back and kind of listen and to have watched this whole evolution of attitudes change.

Huth: Do you think the program's pretty much improved over the years--that the changes that have been taking place are improvements?

Shragg: Oh. yes. I think there's been a lot of improvement. I think the salaries have improved, the facilities have improved--we're still short in quality of facilities--the benefits have improved. It used to be frustrating for the physicians to tell somebody, "Well. we don't cover that"—for example. tuberculosis. some contagious diseases--and the physicians have always been in the forefront of pushing for more and more comprehensive benefits, so that we wouldn't be compromising how we dealt with people. We would, hopefully, take care of all of their medical needs. But when we had somebody with alchoholism we'd have to turn them out, and that was difficult--now we have a substance abuse program. Some contagious diseases were simply not covered. and tuberculosis was not a covered benefit in some of the early years. When patients had it we had to send them elsewhere.

That was very frustrating for physicians, not to be able to take care of the whole combination of illnesses and diseases and so forth. And it still is for those new things, like heart transplants--now we have to refer them off for care, and that's not a big deal, but that's just sort of an example. We'd like to be able to do it ourselves for good quality care.

Insuring Quality Care: Illness Prevention, Nurse Practitioners, the Elderly, and Access to Care

Huth: I wonder if you would comment about the new emphasis on--well, it's not so new anymore, but it was--on prevention and early detection, that's part of the program.

Shragg: Well, see, I think that's a myth, in the sense that prevention--whatever prevention is--and early detection have always been basic to providing health care. So it's nothing new. What is prevention? The only real preventive measures that we know work are immunization shots. That's the only thing that I can think of that really, really works. You can say, "If you get a tetanus shot, you're going to prevent tetanus." I mean, that's the only preventive medical care.

Most of the other health care preventatives that have occurred have been through engineering and sanitation, the plumbing, and the purification of water supplies--that's not what we're talking about. The annual physical examination was a myth in the days when everyone was propounding it--it's still a myth, and we're trying to change that. You could call prevention doing prescreening, and cancer tests, whatever are known and they've known in the past, hematocrit tests, and trying to have a good diet. Doctors were never opposed to good diets in the past. As we learn more we apply what we learn, as does anybody else. I don't know that we're necessarily unique in that respect as a health care delivery system. What we do provide is, I think, twenty-four hour a day coverage for those who get ill.

Huth: What about member education? Aren't you doing more with that in your mailings to members?

Shragg: We're doing more with mailings; we've done it a lot of times. There probably is more education done on television than any place else in terms of it's effectiveness. We spend a lot of money--I think we have to--but I think much of it is wasted in terms of it's effectiveness in giving people printed material to read, because people don't read, they don't listen. You know, I don't think we're unique in trying to tell people to quit smoking--they do it all over. And they do or they don't, I think.

So I think it's part of a whole. I don't think we're unique. I think the schools and educational systems have to do those things as well.

Huth: What about the growing use of nurse practitioners? Any comments about that?

Shragg: Yes, I think they're good. I think there's a role for them; there's a definite place for them. I think it's not as all- pervasive as some people would like to believe, and I was one of those in the early days of development. I think where used and used appropriately they're very effective. There'll be a problem with them in the future as we get a surplus of physicians--I don't think there's any question. In terms of training, or one-on-one, a physician is more versatile, can take night-call, which a nurse practitioner doesn't, and can be more beneficial. But at the moment we think, but are not certain that they're cost effective to use; they can do a good job. The trained ones are very good.

Huth: What about the need for improvement in medical care for the elderly?

Shragg: That's such a critical need, and that may be an area where Kaiser Permanente could again lead the country. I don't know how to do it.

Huth: Could it be more costly?

Shragg: Oh, very costly. Care for the elderly is costly, but if we could come up with something--and it's costly--and if we could again be that creative new kid on the block with something to give--. I don't know what the answer is. We've all experienced that. I've experienced it with my own family, and it's terribly depressing. But that's a fabulous need.

But it's a societal responsibility. It isn't just uniquely a physician or medical care program, except then we integrate it into societal requirements and societal support--financial support in particular.

Huth: Another observer has said that some of the weaknesses of Kaiser are the lack of access.

Shragg: Yes, but that's, again, for elective things. I remember interviewing a physician just out of Boston, just a young guy, and he was imbued with the Kaiser Permanente concept--prepaid medicine. I've always tried to be candid and honest, and I told him what I thought were some of the negatives, and one of them was just this sort of thing. He said, "Yes, but when you're sick there is no barrier to access--no economic barrier, and there's no physical barrier because we have here an excellent staff twenty-four hours a day." And he's absolutely right. So that is a priority, and it goes back to the telephones and routine physicals, and that's just a matter of money.

Huth: The next one was that it operates for the doctors' convenience.

Shragg: Well, that's just not true.

Huth: These are comments that people make as criticisms.

Shragg: Sure, sure.

Huth: Is there impersonal care?

Shragg: Well, again, I can show you people and comments that it's not the system that's impersonal--it's the individual doctor that's impersonal. The answer is, with two thousand doctors we have many impersonal doctors, but we have many that are just as caring as anybody else anywhere. The system does not accept impersonal things, it's the individual. Not a lot we can do, except to keep them abreast of it, but we have all sorts of comments pro and con about that.

A Look Back at Accomplishments

Huth: I have about three more questions.

Shragg: Go ahead!

Huth: One is, what do you consider to be your greatest accomplishment?

Shragg: I guess, surviving [laughs].

Huth: [laughs] Survival. That's a great answer, actually.

Shragg: My greatest accomplishment?

Huth: Almost the same thing, and I might include it with this, was, what was your major contribution?

Shragg: I guess my greatest accomplishment is the feeling that I mentioned earlier about being there the night that the sixteen-year-old black girl came in, and I was part of the team that gave her fabulous care. Emotionally, that certainly is it.

The other part is whatever input I had in trying to establish, and retain, and maintain a competent staff. And we have several who are not so competent, unfortunately, in terms of being caring people. I guess my involvement with the PCC [parent child center] program is something that I'm proud of. I think that the thing that probably what I'm most proud of, is--medical facilities. I've really enjoyed it. I think whatever involvement or contribution I've made in that respect--in terms of physician involvement--I guess, would be another facet. Helping to develop a solid plastic surgery program in southern California is, perhaps, another contribution that I was involved in.

But none of those compare to really taking care of patients, from a very personal standpoint. Every so often I still get a call from a patient of ten, fifteen years ago, who remembers me, and calls me because they're in trouble, and they happen to find me. Nothing gives me more personal ego, or caring satisfaction than that.

Huth: Have you ever thought about what your life would have been like if you had not joined Kaiser, and had stayed in fee-for-service?

Shragg: Yes. I've thought about it [laughs]. We've had problems, and there have been times when we had regrets and wondered about it--many, many times. But over the years I must say I've never had any regrets that I joined this program. I've been proud of it, and I've been aware of it's deficiencies. It's just not perfect.

It helps to have friends of mine who are in private practice, who themselves are successful, and to listen to their gripes and their moaning and groaning. They have problems and we have problems, and there's just nothing that's really perfect. But for my personality and my needs this has been a good professional life, and I've had very little regrets. I'd like to do things different, but that would be true of any kind of an environment that I would have been in, I'm sure.

On Retirement Plans

Huth: Have you thought about your retirement years?

Shragg: Oh. lots--sure.

Huth: What plans do you have for your future with the medical care program?

Shragg: Well, I've had lots of thoughts about it. And my plans are, at the moment--again, within the southern California Permanente, I have an opportunity, and also a right, by our rules and regulations: those physicians who are in administration for an extended period of time, when they get through with their administrative responsibilities have available to them up to a year to be retrained so that they can return to an active clinical practice. So I thought about that--I talked to Dr. Murray, and my objective is that I will begin getting back to some phase of surgery, not full, general surgery.

At the moment my objective is to get into breast reconstruction, which is one of the benefits for women with breast cancer--a health plan benefit that I think is a tremendous one, and therefore for which there will always be a need. So I can feel that

I can hopefully do a good job and get my personal rewards by taking care of patients again. So I have that in mind, with the hope that, if I'm healthy enough, I'll be able to continue on in that capacity.

Huth: Do you foresee full-time work at whatever this is, or will you try to taper off?

Shragg: I think I would, at the moment, probably start tapering off. I think so. And that's why this has an appeal. Because it's the kind of practice that I can do on a part-time basis without impacting my colleagues, or making them do work for me. I have some problem with people on part-time who expect others to really do their work for them. I've always resisted it and resented some of it, and hopefully this will not be that. If it does become that, I think I'll be disappointed, and I won't ask my colleagues to do more than I would in turn give them in terms of helping each other.

I don't want to be isolated as an ex-medical director. I want to be one of the boys, so to speak. That was the sort of thing that I resented, when I went into administration was I first recognized that I was being treated somewhat differently by my physician colleagues at the time.

Huth: Have you already started getting ready for retirement, in that you're doing other things than you have done all along, or are you making some preparations?

Shragg: Yes, I have, and I think it's been to my benefit. My exposure to the plastic surgeons, I guess, has been one of the areas that has been helpful. They have sort of helped me along that line. I was looking for a phase of surgery that would not require night-call, and emergencies, and that kind of stress, which at sixty-five I don't want to do, nor do I think I'll be able to do. So I want something that is more elective, and yet personally rewarding and satisfying.

I think this will do it, so I have already embarked on making contacts with different people throughout the country who say they will welcome me to come and work with them--various experts in the field and so forth. So next year, for example, I'm planning--if everything works out all right--to take off three months, like on a sabbatical, to go to Atlanta, Georgia, where they have two very outstanding people in this field. I've established contact with them.

Huth: Will your wife go with you?

Shragg: Oh, sure. We have a major benefit here, in terms of sabbaticals. They're really extended leaves. A lot of doctors have taken advantage of it, and I have never done that. Part of it was because it was difficult in this job, and I've sort of resented not having

that opportunity to take off and train, and observe, or go back to school, or something like that. So I'm really looking forward to that benefit which I'm entitled to.

Huth: Is there anything else you want to say, any closing remarks, any overview comment about the Kaiser Permanente philosophy?

Shragg: Well, I think the basic philosophy is still there. I see changes in various management techniques and ideas, and the thrust on marketing that I hope will not adversely affect the basic premise of the program. We have established a norm which the country is now emulating. For example, in the urban centers--and I can't speak to the rural areas--the idea of having a group of major providers associated and adjacent, or part of a hospital complex, has been such a tremendous asset in terms of the quality of life for the physician. And other people have been emulating it, so every major hospital in Los Angeles, at least, has right next to it an enormous medical office building that physicians do use as their private practice offices. They essentially are copying us, and that's good.

I see a hint, a direction, an idea, that in order to have exposure to more people, and therefore better marketing, of going back to its ridiculous extreme of a doctor upstairs over every corner drugstore--like it was in the '20s and '30s--I consider that to be counterproductive, because I think that's poor quality care, even though patients may say, "Yes, I like somebody who is around the corner." But I think that if you're within fifteen to thirty minutes of a medical center in the southern California climate--and not in Minnesota, where fifteen to thirty minutes in January is an enormous undertaking--its plenty good enough.

And it provides an opportunity to have groups of physicians--at least twelve, I think--that would justify laboratory, x-ray, and support systems to be a preferable way to go. And not to have to look at our competition, who try to get one or two doctors in a community, and think that that's the best way. Because I think they're doomed to failure. I think patients will see quickly that if you want good care and present-day twentieth century and twenty-first century medicine, you have to go where there are groups of specialists, primary care doctors, and all the technological resources that everybody wants for themselves--in spite of the hue and cry that medicine needs more art than technology--and that's true. The fact is, they want the art and the technology, and you're not going to get it in a small office that just happens to be located in some neighborhood.

We now have experienced people [health plan members] who live in the Inglewood area where we have a lovely physical facility with thirty doctors, who simply passed them by to come here [to the larger West Los Angeles facility] because they want to go to the medical center. The marketing people don't understand that.

Because if you ask a patient, "Do you want something close by? the answer obviously is going to be, "Yes." Everybody would like to have a whole medical center conveniently located in their backyard.

I'm afraid we're going to be trapped more and more to that kind of notion. And I think it'll be costly, and I don't think it'll be very effective in terms of the quality of medical care that we have to provide in this day and age. I would like to see us attack the quality of service thing. But I don't think training programs help a whole hell of a lot. They help a little bit-- the doctor has to be the role model, and should be. And if we could have more telephone access I think we would resolve the major, major problem that we have.

And then we have to be patient because I'm convinced that the quality of care that we provide, in the long run, will stand us best. Some of the other competitors that we're now concerned about--as they cut corners more than we do as in the example of the Maxicare patient who was not permitted to be in the hospital the night before—I think they'll fall by the wayside. But I think we have to be more accessible to our patients and considerate of them. So maybe in answer to the question you asked earlier about, "procedures for the convenience of the doctor?" to which I said, "it's not true,"--on the other hand, it may mean that we need to have more on duty evening hours and weekend hours for the needs of the working family--when there are two providers in a family and so forth.

We do have access for those people. We may have to improve that, but that's not because it's for the benefit of the physicians--but we may not have as much as everybody would want. What the average health plan member who wants this doesn't understand is. that when we had Saturday and evening clinics, the number of people who just failed to show up was staggering--and therefore it was very costly. But we have to look at that, and we are, and every other area is looking at that, to try to see how we can improve our access from that standpoint. I think we need that.

Huth: Thank you for giving me your time. I think you did an excellent job of answering these questions.

Shragg: It's been fun for me. Well, I try to be honest.

Huth: I appreciate it very much.

Transcriber: Johanna Wolgast
Typist: Ann Schofield

TAPE GUIDE---Harry Shragg, M.D.

HARRY SHRAGG, M.D.

ASSOCIATE MEDICAL DIRECTOR, WEST LOS ANGELES AREA
SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP
CHIEF OF STAFF, KAISER FOUNDATION HOSPITAL

Dr. Harry Shragg joined the Southern California Permanente Medical Group in 1957 as a surgeon in Harbor City, where he became Chief of Surgery in 1959 and Associate Medical Director in 1965.

He transferred to Inglewood in 1970 when facilities opened there to expand service to what is now the West Los Angeles service area.

After receiving an M.B.degree from the University of Minnesota in 1946, Dr. Shragg received his M.D.a year later from the same institution. He served a rotating internship at Hennepin County General Hospital in Minneapolis and, from 1948 to 1951, was in general practice in Elmore, Minnesota.

Dr. Shragg's residency in general surgery was completed in 1957 at the Minneapolis Veterans Administration Hospital after being interrupted for two years (1951-1953) by service as a medical officer in the Air Force.

A member of the Association of American Medical Clinics, Dr. Shragg also currently serves as a consultant to the Veterans Administration Health Care Committee of the National Research Council.

CURRICULUM VITAE

HARRY SHRAGG, M.D.
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6041 Cadillac Avenue
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Born: August 19, 1924, Minneapolis, Minnesota
Marital Status: Married with two children, ages 35 and 37

PROFESSIONAL DATA

1964 - Present	Member of Board of Directors Southern California Permanente Medical Group
December, 1971 - Present	Associate Medical Director Southern California Permanente Medical Group West Los Angeles Area
1965 - 1971	Associate Medical Director Southern California Permanente Medical Group Harbor City Area
1968	Appointed as Physician-in-charge of planning the West Los Angeles Area and its new facilities. This was followed by developing and building a staff of physicians incorporating 3 existing outlying clinics; La Cienega, WLA, and Inglewood, previously associated with the Sunset Area
1959 - 1965	Chief of Surgery Southern California Permanente Medical Group Harbor City Area
1959	Certified - American Board of Surgery
January 19, 1957	Joined the Southern California Permanente Medical Goup, Department of Surgery, Harbor City Area
October, 1953 - January, 1957	Residency in General Surgery Minneapolis Veterans Administration Hospital
October, 1951 - October, 1953	Medical Officer United States Air Force
January, 1951 - October, 1951	Residency in General Surgery Minneapolis Veterans Administration Hospital

CURRICULUM VITAE
HARRY SHRAGG, M.D.
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PROFESSIONAL DATA (cont'd)

1948 - 1951	General Practice Elmore, Minnesota
1947 - 1948	Rotating Internship Hennepin County General Hospital Minneapolis, Minnesota
October, 1943 - March, 1946	Enlisted- United States Army

EDUCATIONAL BACKGROUND

1947	M. D. Degree from the University of Minnesota
1946	M. B. Degree from the University of Minnesota
1941	Graduated from North High School, Minneapolis, Minnesota

ASSOCIATIONS

American Group Practice Association
Association of American Medical Clinics (AAMC)
California Medical Association (CMA)
Health Association of America
Los Angeles County Medical Association (LACMA)
Member of Medical Directors Division of the Group

COMMITTEES

Los Angeles County Medical Association, Area Hospital Representative, 1980 -1981

American Group Practice Association, Health Care Economics Committee, 1979 - 1980

Member of SAC of Health System Agency 1979

American Group Practice Association, Health Care Planning Committee, 1978 - 1979

American Group Practice Association, Underserved Areas Committee, 1977 - 1978

Consultant to VA Health Care Committee, Division of Medical Sciences, National Research Council, June, 1974 - May, 1975

Participant in HMO Panel before Hospital Council of Southern California, September, 1974

State Health Services Committee, 1960 - 1973

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COMMITTEES (cont'd)

Speaker at Group Health Institute Course on HMO Development, November, 1972, Puerto Rico

Panel Participant for Group Health Institute Meeting in Detroit, May, 1972

Participant in Group Health Institute Course on HMO Development in Los Angeles, April, 1971

PUBLICATIONS

June, 1973 — "Low-Income Families in a Large Scale Prepaid Group Practice", Inquiry

1949 — "Inversion of the Uterus" Case Report Minnesota Medicine

RESEARCH PROJECTS

Applied Research Funds from Kaiser-Permanente Research Program, "Health Care Changes in a Low Income Group"

September, 1985

Harry Shragg
Myrna E. Fagenbaum
Joel W. Kovner
Helen M. Caro
Edward D. Bunting

Low-Income Families in a Large Scale Prepaid Group Practice

Increased national concern for the social, economic and health problems of the nation's low-income population in the early 1960s was accompanied by recognition that adequate medical care remained largely out of reach of this population. The question of whether a need exists has become, instead, one of how to meet this need in face of rising medical care costs, limited resources, and possible special requisites of a particular population. With a growing general acceptance of the idea that medical care is a right rather than a privilege, the pressure is strong to develop cooperative arrangements among the existing medical care systems and community agencies to meet what has become both a human and political demand.

In April, 1968, the Southern California Kaiser-Permanente medical care program was asked to extend its services to a group of low-income families through an arrangement that in many ways is unique in its appeal to a direct working cooperation between a private medical care system and a federally funded social welfare program.

Specifically, Kaiser-Permanente in Southern California, a prepaid group practice serving a predominantly working population, has been providing without charge medical care services to 100 families who participate in the Parent-Child Center (PCC) program in Harbor City, California, an area in the southwest section of Los Angeles County. The PCC program, funded through various government agencies, provides a range of social services to 100 families who are residents of a census tract incorporating a city-operated housing project. It is a demonstration project attempting to maximize the potential of children under three through a comprehensive problem-solving effort directed at strengthening the family unit as a whole.

Almost half of the PCC participants are Mexican-American (48 percent); other ethnic backgrounds represented are Blacks (24 percent), Caucasians (16 percent), and Pacific Islanders (12 percent). All met the following criteria: low household income according to Office of Economic Opportunity (OEO) guidelines, and the presence of a child three years of age or younger or an expectant mother within the household.

The PCC program, through a staff of community service workers, addresses itself to such problem areas as job training and placement, family and consumer education, recreation, and medical and dental care, etc. Kaiser-Permanente contributes by providing dues (from its own community service program) for enrollment into the Kaiser Foundation Health Plan. Benefits are comprehensive in terms of both inpatient and outpatient services and involve no over-the-counter charges to the PCC participants. The services are pro-

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vided almost entirely at the Kaiser-Permanente Harbor City Medical Center, located directly across the street from the PCC target area.

The discussion which follows will include a description of the working agreements reached between Kaiser-Permanente and the PCC program, as well as a description of the first year's experience in providing medical services, and comparative statistics on the utilization of the PCC participants and a matched sample of regular Kaiser Foundation Health Plan members.

Background

The Kaiser Foundation Health Plan and Permanente Medical Group were interested in becoming involved with the PCC group for a number of reasons. In particular, the staff at Harbor City saw this as an opportunity to become involved in the community in an effective way. Furthermore, they felt that the Kaiser-Permanente system lent itself to the provision of quality medical care in a more comprehensive manner and with greater continuity and less stigma than this population had been exposed to previously, and that this could be achieved without changes within the Kaiser-Permanente system.

Currently, Kaiser-Permanente serves more than 900,000 members throughout Southern California. The Medical Center in Harbor City, with 170 acute beds and about 95 physicians on its staff, serves about 100,000 of these members. Most of these individuals have become members through their place of employment and thus represent a cross section of the community's working population.

Kaiser-Permanente agreed to provide services to the PCC families as it would to any other group. This implies integration of the PCC population into an ongoing medical care system, and accessibility to comprehensive medical care services for this group, provided economically and equitably. The effort would be considered successful in terms of quality of care, economic feasibility and integration of the families into the system if, over a period of time, the providers of care related to the members of this group as they do to other Health Plan members, as expressed by provider attitudes toward the enrollees, and enrollees' attitudes toward the provider (as demonstrated by utilization patterns).

When Kaiser-Permanente said it would treat the PCC group like any other Health Plan group, this meant the following: PCC members would receive regular Health Plan identification cards distinguishable only by the letter "J", which indicates the coverage to which the members were entitled. (A letter code to indicate different types of coverage is used for all groups.) They would become eligible for all medical care services available at the Harbor City Medical Center, and have additional links to the system through the Membership Service Department, and through their own community service workers.

It also meant that Kaiser-Permanente would hire no special staff and would offer no direct outreach services. The system would, however, provide an orientation for these new Health Plan members on the services available (as is provided for all groups upon request), and would pay special attention to establishing strong communications links between the patient and the system and between the PCC community service workers and the system. Kaiser-Permanente did make a point of assuring direct access for PCC members and staff to the medical center administration in an effort to achieve prompt resolution of problems and alleviate any initial fears of the system.

Guidelines Established

From the program's inception, efforts were made to minimize confusion and conflict by clarifying roles and delineating responsibility. Accordingly, the following guidelines were established:

1 Eligibility for enrollment would be determined solely by the Parent-Child Center staff, re-emphasizing that Kaiser-Permanente's role was to contribute to one aspect of a total program.
2 Kaiser-Permanente would assume and

maintain direct responsibility for providing medical care.

Because of the nature of the Kaiser-Permanente program, enrollment of PCC eligibles required initial acceptance by the medical staff that was to provide the care. Most of the areas of concern were covered by the guidelines. Other concerns, however, could not be dealt with as concretely: 1) the question of continuing coverage if the PCC program were not refunded; 2) the possibility of "excess" utilization because of proximity to the medical care facilities; and 3) the possibility of external constraints and the fear that excess paperwork would be required of physicians.

Regarding these concerns, the first question never has been fully answered — Kaiser-Permanente has not made a decision regarding funding if the PCC program itself is terminated by federal action. However, a decision to proceed was made on the conviction that the opportunity to receive medical care, even for one year, would be of enough value to the target population to offset whatever eventualities might arise.

The second area of concern was mitigated somewhat because experience in the Portland region of Kaiser-Permanente, as well as in other medical care programs for low-income populations, demonstrated no "abuse" in terms of utilization. However, the Medical Group remained wary due to the proximity of the PCC target area to the medical facilities.

The third point reflected the Medical Group's concern about constraints beyond those applicable to present groups that might be imposed on the Kaiser-Permanente system because of federal sponsorship of the PCC program. Specifically, Kaiser-Permanente wanted to avoid paperwork requirements for excessive reporting of utilization, as these would burden the medical staff and would also imply explicit identification of PCC members as different from regularly enrolled Health Plan members. A decision was therefore made that physicians would be protected from excess paperwork, and that only data already generated by the ongoing system would be collected for this group.

Results: Provider Attitudes Toward Enrollees

If it can be correctly hypothesized that the PCC group, after the critical period of initial enrollment and adjustment to a new system of medical care delivery, will use Kaiser-Permanente facilities in the same manner as other Health Plan groups, then it follows that the relationship between the PCC group and the Harbor City Permanente Medical Group can be expected to be similar to the relationship between the Medical Group and other Health Plan groups.

The divisions of responsibility agreed upon by PCC and Kaiser-Permanente were adhered to diligently and proved helpful. Thus, when PCC made changes in the longevity of residence requirements in determining eligibility, Kaiser-Permanente was not affected. In the area of medical services, PCC administration did not interfere, but cooperated with Permanente physicians to help assure the proper follow-up of care. Lines of communication were kept open and made possible the solution of problems, most of which resulted from personality differences or misunderstanding as to how to utilize the medical services.

After the decision was made to enroll the PCC eligibles, problems did arise which highlighted the lack of experience of the medical care system with low-income populations and vice versa. The first such case was perhaps a result of overenthusiasm. The initial 28 families were enrolled on April 21, 1969. In an attempt at efficiency, one evening was set aside both for enrollment and a general orientation. A team of nurses, receptionists, supervisors and physicians sought to give a thorough explanation of the appointment system, facilities, and range and use of services. The PCC families, however, were overwhelmed with the total organization and could not assimilate all of the information. As a result, the initial period of enrollment was extended from the planned

period of a few weeks to a few months to allow less intensive, more frequent orientation sessions for smaller groups, and to lessen the impact of numbers on the staff.

Another problem area was the large percentage of appointments (25 percent) made by PCC members which were not kept and not canceled. Made aware that this group of patients was crises-oriented and accustomed to long clinic waits, the Medical Group worked out an arrangement with PCC community service workers to remind the patients of appointments and to educate them to the importance of keeping these appointments or canceling them in advance. Over a period of time, the PCC members responded to these efforts and their record of missed appointments decreased to a level similar to that of other Health Plan members (or approximately 10 percent).

From the outset, it was not possible to make the PCC group totally indistinguishable from other Health Plan groups. The letter "J" on the cards did indicate to Kaiser-Permanente employees that the members belonged to PCC, since no other group has exactly the same coverage. Although a distinguishing identifier to the providers, the passage of time has resulted in the letter "J" being analogous to PCC members as the letter "X" to retail clerks or "D" to longshoremen.

Prejudice and Resistance

Problems did arise in some attitudes of the staff. Although, generally speaking, the addition of the group caused reactions or attitudes not discernibly different from those exhibited toward any new group, a few of the staff did manifest some prejudice and resistance. Furthermore, the type of these reactions differed in some cases between paramedical and physician personnel.

When paramedical personnel had bad encounters with PCC participants, it was easy to say, "Oh, it's one of those people from PCC"; but such reactions also occur with other Health Plan groups. Perhaps Kaiser-Permanente employees were more sensitive if a PCC patient offended them than if a member of another group was the offender. Overall, an attempt was made to ask for or provide apologies as indicated, just as is done with other groups.

Basically, however, whatever paramedical personnel prejudice surfaced (only a few staff members were involved) was not racially directed, but focused on "poor people" or "people on Welfare"—with the attitude being, "Why should these people get something for nothing?" and that perhaps they were not entitled to. Where incidents occurred, they were few and were handled directly, promptly, and decreased in frequency as time went on.

The attitudes of the physicians toward this program were somewhat different. A number were very much in favor of the program, especially those who were more directly involved. However, the majority did not comment one way or the other about the merits of the program, except for one physician. His prejudice was a political one; it was simply one against the "Welfare State" generally, with the implication that everything that is 100 percent "Welfare" is bad. He firmly believed that all able-bodied people can and should work, and that there is literally a job for everyone. He offended a number of these people by asking: "How come you don't have a job?" or "Why aren't you working?" The problem was resolved by not making appointments for PCC patients with this physician because of fears of his offending them, rather than concern that treatment would be different from that provided any other patient.

After a year of implementation, the impact of PCC enrollment led to the evolvement of a different type of sentiment than expressed initially. Because of the success in integrating PCC members with regular Health Plan members, a genuine concern was voiced as to what would happen to this group medically if the program were not refunded.

It is easy to state an objective that a low-income population will be treated like any other group and should encounter none of the stigma which has been part of their life's experience. Yet this is diffi-

cult to accomplish and even more difficult to measure.

While objective guidelines can be set and official policies adhered to, special feelings and considerations did accompany the enrollment of these families into the Health Plan. The challenge was to deal with these situations as they arose and strive for an end goal of mutual acceptance.

After the first year of the program's implementation, the expectation that the relationship between the PCC group and the Harbor City Permanente Medical Group would be similar to that between the Medical Group and other groups having Kaiser-Permanente coverage seems to have been realized. Physicians continue to be concerned about the future of the program, but now express the sentiment that Kaiser-Permanente should continue to provide care to this patient population whether or not the program is refunded.

Staff prejudices and anxieties, such as they were, seem to have been overcome in the main; the PCC members in turn have been learning to understand the Kaiser-Permanente system. Both groups have learned from one another so that it was possible to break down barriers and integrate the PCC group into the Kaiser-Permanente medical care system.

Enrollee Attitude Toward Providers

It is difficult to measure and thus judge the success in reaching a goal that depends on a relationship and involves feelings and attitudes. It is, however, possible to draw certain conclusions from actions, which can be measured. It is assumed that one way of measuring the attitudes of a group enrolled in a medical care system is to measure their patterns of utilization within that system. Furthermore, if their utilization patterns approximate those of other members, then it is assumed, as far as medical care services are concerned, that the group has been integrated into the system in a manner similar to other groups.

When Kaiser-Permanente agreed to provide services to the PCC families, plans immediately were made and implemented to develop a data base to allow comparison of utilization of services between the PCC participants and the general Health Plan membership.

To test the hypothesis that a low-income group could be integrated successfully into the Kaiser-Permanente medical care system, inpatient, outpatient and pharmacy utilization data were collected on all PCC participants and on a sample of Kaiser Foundation Health Plan (KFHP) members matched as closely as possible according to area of residence, type of coverage, and family composition. Specifically, a sample of 100 KFHP subscriber units was selected randomly from among those living in the Harbor City area having at least a basic Kaiser coverage requiring a minimum of over-the-counter charges for services. Coverage is held constant as a variable because of the possible effects of explicit price on utilization; the variation in explicit price for both samples is minimal and differs only in terms of prescription drugs, where the KFHP sample remits, on the average, 30 percent of the explicit price and the PCC group remits none of the explicit price.

Utilization data will be presented for the entire PCC group, but will be broken down into two subgroups: those covered by Title XIX (Medi-Cal), and those who are not. Since Medi-Cal recipients can receive care at non-Kaiser facilities at little or no cost while non-Medi-Cal participants cannot, data are presented separately for each.

Comparative statistics are presented primarily as utilization rates computed monthly to account for seasonal variations, and proportions computed annually. Where appropriate, tests for statistically significant differences between proportions were performed to control for the factor of chance. Correlation tests were performed to test the interrelationships of various factors.

Interpretation of the results must take into account the fact that the KFHP membership sample has had a longer exposure to the Kaiser-Permanente medical care

Table 1. Annual average enrollment, PCC group and KFHP sample group

	PCC			
	Medi-Cal	Non-Medi-Cal	PCC total	KFHP total
Subscriber units	42	39	81	91
Total members	225	247	472	440
Average members/subscriber unit	5.31	6.37	5.81	4.81

Note: Totals represent average subscribers during the period under study for both PCC and the KFHP sample; enrollment occurred on a staggered basis.

system: 66 percent of the members and 72 percent of the subscriber units were enrolled for an average of 21 months prior to the beginning of the PCC program.

Demographic Data

Tables 1 and 2 show the membership breakdowns of the groups being compared. The family size of the PCC group is slightly larger than that of the KFHP sample. Age-sex distributions of both groups are similar except for the smaller proportion of adult males in the PCC group.

The difference in the proportion of male adults in the PCC group and the KFHP sample is statistically significant at the .05 level. These differences, especially as regards the percentage of adult females for PCC versus the KFHP sample could have an impact on utilization comparisons. However, as can be noted in subsequent tables, utilization data for the PCC non-Medi-Cal group—which in family and age-sex composition more closely approximates the KFHP sample than the PCC Medi-Cal sample—do not present substantially different patterns from the PCC Medi-Cal sample. For example, despite family composition differentials, the percentage of those not utilizing is not significantly different (at the .05 level) between the PCC Medi-Cal and non-Medi-Cal samples. Similarly, annualized doctor office visit differentials between PCC Medi-Cal and non-Medi-Cal are not significant.

Within the PCC group alone, the difference between the proportion of male adults in the Medi-Cal and non-Medi-Cal segments also is statistically significant at the .05 level, reflecting the fact that two-thirds of the Medi-Cal subscriber units are one-parent households in which the father is not present. By contrast, the father is almost always present in the non-Medi-Cal subscriber units.

Table 2. Percentage distribution by age and sex, PCC group and KFHP sample group

	PCC			
	Medi-Cal	Non-Medi-Cal	PCC total	KFHP
Male adults	9.5	18.5	14.2	23.0
Male children*	38.0	29.9	33.8	28.5
Female adults	21.9	19.3	20.5	21.5
Female children*	30.6	32.4	31.5	27.1

*Those 14 years of age and younger are considered children.

Non-Utilizers

A non-utilizer is defined as a person who has not had any contact with Kaiser-Permanente facilities since enrolling as a Kaiser member. If a person enrolled on February 1, 1970 or later, he is excluded from the non-utilizer category because he may not have had time to arrange an appointment, be seen by a physician and/or have the information about the visit recorded in his chart before the study period ended on April 30, 1970.

Non-utilizers comprise 25.6 percent of PCC members, compared to 19.3 percent of all members in the KFHP sample, a statistically significant difference at the .05 level. Similarly, the proportion of PCC subscriber units containing non-utilizers is higher at a statistically significant level than that of KFHP subscriber units containing non-utilizers, 59.3 percent and 43.9 percent, respectively (Table 3).

Outpatient Utilization

Outpatient utilization is based on doctor office visit (DOV) rates. Any doctor-patient contact which occurs through an appointment, walk-in, or emergency room visit is considered a DOV.

Table 3. Data on non-utilizers, PCC group and KFHP sample group

	PCC			
	Medi-Cal	Non-Medi-Cal	PCC total	KFHP
Percent of membership	25.2	25.9	25.6	19.3
Percent of subscriber units having non-utilizers	55.6	63.3	59.3	43.9
Number of non-utilizers/ subscriber unit containing non-utilizers	2.50	2.40	2.60	2.12

Table 4. Outpatient doctor office visit rates per member per year, PCC group and KFHP sample group

	PCC			
	Medi-Cal	Non-Medi-Cal	PCC total	KFHP
May-July 1969	3.66	2.91	3.29	2.75
August-October 1969	1.70	2.63	2.57	2.85
November 1969-January 1970	2.89	2.73	2.80	2.95
February-April 1970	2.66	3.68	3.19	2.77
Total	2.88	2.95	2.91	2.80

The trends in DOV rates per member follow the same pattern for all groups, with the annual DOV rate for PCC members (2.91) slightly exceeding those for KFHP members (2.80) (Table 4).

The major differences between the PCC and KFHP rates appear in the first four months of the study period. Age-sex adjustments resulted in no major difference in the PCC group's DOV rates.

Annual DOV rates per subscriber unit for the PCC group also somewhat exceed that for the KFHP group. This is to be expected since the PCC group averages more persons per subscriber unit, and a higher DOV rate per member.

PCC members covered by Medi-Cal and living in one-parent households produce the lowest annual DOV rates both per member (2.61) and per subscriber unit (12.30). Two-parent households with Medi-Cal coverage show the highest outpatient utilization: 3.20 DOV's per member per year, and 21.18 per subscriber unit per year.

Table 5. Inpatient utilization data, PCC group and KFHP sample group

	PCC			
	Medi-Cal	Non-Medi-Cal	PCC total	KFHP
Number of patients	14	19	33	38
Number of admissions	15	21	36	45
Number of patient days	69	107	176	147
Number of patient days/ 1,000 members/year	325	432	383	334
Number of newborns	5	5	10	30

Inpatient Utilization

Table 5 presents the inpatient utilization data. Because the sample sizes of 36 hospital admissions for the PCC group and 45 admissions for the KFHP sample are too small to be statistically reliable, the findings in this section are tentative. For example, one PCC patient accounted for 28 days in two admissions, thus biasing the average length of stay because of one event.

The proportion of PCC hospital admissions to all members is 8 percent and the proportion of KFHP hospital admissions is 10 percent. The difference between these two proportions is not statistically significant. The average length of stay per admission is 4.9 days for the PCC group and 3.3 days for the KFHP sample. The difference between these averages is statistically significant at the .05 level and not statistically significant at the .01 level. Of hospital admissions, 8 percent for the PCC group and 16 percent for the KFHP sample were readmissions, the difference statistically significant at the .01 level.

A further difference, statistically significant at the .01 level, was found between the two groups in the proportion of admissions culminating in deliveries—for

Table 6. Pharmacy utilization rate by number of prescriptions filled per member per year, PCC group and KFHP sample group

	PCC			KFHP	
	Medi-Cal	Non-Medi-Cal	PCC total	Non-benefit	Prepaid drugs
May-July 1969	1.74	1.88	1.81	1.61	2.24
August-October 1969	1.76	2.91	2.36	1.61	2.51
November 1969-January 1970	2.43	2.76	2.60	1.76	2.71
February-April 1970	2.25	3.46	2.88	1.76	2.81
Total	1.99	2.71	2.37	1.69	2.57

the PCC group, 28 percent; for the KFHP group, 67 percent. The greater frequency of fatherless households among the PCC subscriber units probably is responsible for the lower number of obstetrical admissions and possibly also accounts in part for the lower readmission rate. Because of selection methods for the KFHP group, it is possible that a woman entered the hospital for obstetrical reasons at the beginning and before the end of the study period. This was less of a possibility for the PCC group.

Pharmacy Utilization

Pharmacy utilization of the PCC group was compared to utilization by KFHP members who have no drug benefit and, therefore, must pay community rates for drugs, and to KFHP members who have the prepaid drug benefit, affording them substantial reductions in over-the-counter charges. Rates reflect the number of prescriptions filled per member per year (Table 6).

Annual utilization of the pharmacy by the PCC group (2.37 per member) was greater than that by KFHP non-benefit members (1.69 per member), but slightly lower than that by KFHP members having the prepaid drug benefit (2.57 per member).

Within the PCC group, the proportion of utilizers is greater for non-Medi-Cal members (32.8 percent) than for those covered by Medi-Cal (23.7 percent). Non-Medi-Cal members had a higher average annual utilization rate (2.71) than did the Medi-Cal PCC members (1.99).

Discussion of Results

The hypothesis that this particular low-income group, after an initial period of adjustment to the Kaiser-Permanente medical care system, would utilize services in a manner similar to that of regularly enrolled Health Plan members is substantially supported by the above findings. It is of interest to note that another low-income group, comprised of 500 families enrolled subsequent to the PCC enrollees, demonstrates similar utilization patterns. Whether or not substantially larger increments of low-income individuals enrolled in Kaiser-Permanente would result in similar utilization patterns, remains unknown. However, in the Kaiser-Permanente program, Oregon Region, where 5 percent of the membership are low-income, similar patterns prevail, suggesting that the above results are not atypical.

PCC members did utilize outpatient services at a slightly higher rate than the sample of KFHP members. However, the major differences in utilization rates appeared during the first four months of the program when a special effort was made to bring these new members in for their initial physical examinations. Thereafter, the utilization rates of the two groups began to converge, suggesting that the above hypothesis is in fact correct.

What leaves the finding open to question, however, is the fact that the PCC group had a lower percentage of actual utilizers, so that fewer people were using more services. Isolated, this finding might be explained by patients' lack of familiarity with the plan, since they did have less ex-

posure than the KFHP sample members. If this is true, and if more start to use Kaiser-Permanente services as they become more familiar with the plan, the overall utilization rates may increase substantially. Conversely, if the high utilization by a low number of individuals is traceable to specific medical pathology, utilization rates may drop as medical problems are treated. Thus, while outpatient utilization experience would on face value appear to support the hypothesis, only continued experience will allow more definitive conclusions.

Little support can be drawn from inpatient findings. While there appears little difference in inpatient rates, the size of the samples (36 hospital admissions for the PCC group and 45 admissions for the KFHP sample) is too small to give reliable findings.

Experience with pharmacy utilization perhaps best supports the initial hypothesis. Pharmacy utilization by PCC members falls between that of KFHP members who have the prepaid drug benefit and those who do not. PCC members with Medi-Cal benefits utilize the pharmacy at a rate similar to that of KFHP members without the prepaid drug benefit. Neither group has a strong financial incentive to use Kaiser-Permanente pharmacies for purchase of pharmacy items. This is in contrast to a comparison of non-Medi-Cal members of PCC with KFHP members with the prepaid drug benefit, both groups which use Kaiser-Permanente at a relatively high rate and have a definite financial incentive to remain within the system for pharmacy purchases.

Statistical disaggregations are also suggestive of the influence of Medi-Cal participation on utilization. The findings showed that PCC individuals also eligible for Medi-Cal utilized Kaiser-Permanente services less than did those ineligible for Medi-Cal. This perhaps can be explained by the fact that Medi-Cal pays for services elsewhere; non Medi-Cal PCC patients had no such financial freedom. The one exception to the above was that of male adults in Medi-Cal, who had the highest rate of utilization for all services of all groups. This unusual finding may be related to stringent criteria for qualifying for Medi-Cal benefits. For male adults to qualify, given the comparatively young age range of PCC participants, they probably have a disproportionately high level of medical problems leading to a higher utilization of medical services within or outside the Kaiser-Permanente program. It would be valuable to be able to trace past and current utilization patterns of Medi-Cal participants outside of the Kaiser-Permanente system; however, data are presently unavailable from the State of California.

Summary

Early experience suggests that a system such as Kaiser-Permanente is capable of meeting the needs of a low-income population. The rate of utilization of the PCC group, its similarity over time to that of regular Health Plan members, indicates that a low-income population, after a reasonable period of exposure, will use such a program like any other member, and that the costs of providing medical care can thus also be assumed to be similar.

The PCC experience also suggests that a medical care system can provide such services without itself providing direct outreach services, cooperating instead with a community-based and more comprehensive social-problem-oriented outreach system. This is a somewhat different approach than that usually developed through neighborhood health centers and comprehensive health service programs in which "outreach" is an integral part of the program administration.

The addition of the PCC group to the KFHP membership added little pressure to the system, but rather stimulated the system in a way that may lead to changes of approach—changes which could benefit all Health Plan members and lead to increased awareness and sensitivity of the system to all its members.

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*Unless otherwise specified all place names are California
KPMCP refers to Kaiser Permanente Medical Care Program

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